STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPL			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			A. BUILDING B. WING		07/28/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		S HWY 31 S	
COUNTR	Y CHARM VILLAC	3F		APOLIS, IN 46227	
				1	T
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000000					
	This wisit was f	or a State Residential	R000000		
			KUUUUU		
		ey. This visit included the			
	Investigation of	Complaint IN00152777.			
	Complaint IN00	0152777 - Substantiated.			
	State residential	deficiencies related to			
	the allegations a	are cited at R0052 and			
	R0090.				
	Survey dates: I	uly 23, 24, 25, and 28,			
	2014	ury 23, 24, 23, and 26,			
	2014				
	P 111. 1	00000			
	Facility number				
	Provider number	er: 003283			
	AIM number: 1	N/A			
	Survey team:				
	Karyn Homan,	RN-TC			
	Patsy Allen, SW				
	Dorothy Plumm				
	Marsha Smith,				
	iviaisiia Siiiiui,	KIN (7/23/2014)			
	O1-14				
	Census bed type				
	Residential: 53				
	Total: 53				
	Census payor ty	vpe:			
	Medicaid: 34				
	Other: 19				
	Total: 53				
	10.01. 33				
	Dagidantial ac	mlar 9			
	Residential sam	ipie. o			
LARORATOR	Y DIRECTOR'S OD DDC	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN (OF CORRECTION PROVIDER OR SUPPLIER		7212 U	00 ADDRESS, CITY, STATE, ZIP CODE US HWY 31 S	(X3) DATE SURVEY COMPLETED 07/28/2014
COUNTR	RY CHARM VILLAG	E	INDIAN	NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R000052	Quality review of 2014; by Kimber 2014; by Kim	2(v)(1-6) - Offense e the right to be free from: e; hment; clusion. ew and record review, d to ensure a resident was al abuse in that the arm is grabbed by a staff 8 residents reviewed for on. (Resident #B)	R000052	PLAN OF CORRECTION/COUNTRY CHARM VILLAGE This pl of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on 8/16/2014 does constitute an admission of fau liability to the government enti any third party, on the part of Country Charm Village, as to accuracy of the surveyors' findings of the conclusions dra therefrom. Submission of this plan of correction also does no constitute an admission that the findings constitute a deficience	not It of ty of the awn ot
	During an interv	iew with Resident #B on		that the scope and severity	

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 2 of 71

STATEMEN	IT OF DEFICIENCIES	NCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLETED	
				LDING		07/28/2014	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
COLINITE	N	F			S HWY 31 S		
COUNTR	RY CHARM VILLAG	E		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7/24/14 at 1:35 g	o.m., Resident #B			regarding the deficiency cited	are	
	-	ployee had, "grabbed my			correctly applied. Any changes	s to	
	arm hard" while				the communities policies and		
					procedures should be conside	red	
	attempting to he				to be subsequent remedial		
		icated the employee said			measures as that concept is employed in Rule 47 of the		
	something to the	resident as well, but			Federal Rules of Evidence and	, l	
	could not remem	ber exactly what was			any corresponding state rules		
	said. Resident #	B indicated the incident,			civil procedure should be		
	"hurt my feeling	s" and the resident			inadmissible in any proceeding	g on	
		esident's apartment after			that basis and the community		
		sident #B indicated			reserves the right to object to t		
					admission of this statement of		
		mber was present when			deficiency or the plan of		
		pened and 2 staff			correction under any other the		
	members had ch	ecked on the resident			of law. The community submits	s	
	shortly after the	incident. Resident #B			this plan of correction with the intention that it is inadmissible	hv	
	was reluctant to	report the incident,			any third party in any civil or	Dy .	
		living here and do not			criminal action against the		
	want to have to i	-			community or any employee,		
	want to have to i	move.			agent, officer, director, attorne	y,	
	.				or shareholder of the commun	ity	
	_	iew with the Corporate			or affiliated companies. R		
	Executive Direct	tor (CED) and the			052 – Residents' Rights -		
	Director of Nurs	ing (DoN) on 7/24/14 at			Offense 1. The corrective		
	3:00 p.m., the Cl	ED indicated the facility			action(s) that has been		
	was in the proce	ss of investigating an			accomplished for Resident B	•	
	_	on of physical abuse			was employee identified by		
		ent #B. The CED			Resident B is no longer		
	_				employed at Country Charm Village. 2. The facility		
		ly member of Resident			reviewed each resident's		
		concern to the facility			record and determined all		
	regarding an inc	ident with the Activity			residents could be affected b	,	
	Director (AD) as	nd Resident #B. The			the alleged deficient practice	-	
	CED indicated the	he facility had a new			and all employees were train		
		tor (ED) and the ED had			how to take preventative		
		estigation and filed a			measures against similar		
		•			actions in dealing with their		
	report when the	fax was received on			-		

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 3 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			A. BUILDING B. WING		07/28/2014
				ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2 US HWY 31 S	
COLINTE	RY CHARM VILLAG	F		ANAPOLIS, IN 46227	
				ANAI OLIO, IIV 40221	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
		ED indicated the AD was		emotions when caring for	
	suspended on 7/2	21/14, pending the		residents and also trained of	
	results of the inv	estigation.		abuse. 3. The measures	
		_		will be put into place and the systemic changes the facility	
	During the interv	view on 7/24/14 at 3:00		will make to ensure that the	=
		dicated Resident		deficient practice does not	
				recur include the Executive	
	` ′	4 had reported an		Director or designee shall	
		n 7/1/14, that involved		provide upon hire, a new hi	re
		dent #B. The DoN		orientation that all employe	
	indicated RA #4	had informed her of		are knowledgeable or	
Resident #B becoming upset, because the				resident's rights, including	
	AD had grabbed	the arm of the resident.		physical, verbal, mental and	i
	The DoN indicat	ted Resident #B was		sexual abuse. Staff shall be	
		ncident, but had no		in-serviced on the definition	
	_	The DoN indicated she		of neglect and abuse, include	_
	1			the responsibility to report	any
		Resident #B and then had		issues immediately to the Executive Director, DON, or	
		of the incident. The		department head. A check-o	
		he did not think the		form shall be utilized to ens	
	former ED had r	eported the incident to		all required items of orienta	
	the Indiana State	Board of Health		are completed. It is the poli	
	(ISDH).			of the facility to report any	
				such suspected allegations	
	During an interv	iew with the CED on		immediately (within 24 hour	rs)
		o.m., the CED indicated		to the ISDOH, suspend alleg	ged
		*		employee pending	
	_	ith the former ED		investigation, begin	
	1 -	eident with Resident #B		investigation, and provide a	l
		D indicated the incident		follow up report to ISDOH	ive
	_	isly investigated and was		within (5) days. The Execut Director shall ensure the tin	
	determined not to	o have been a situation		reporting and follow up of a	<u> </u>
	involving abuse	and a report was not		reporting and follow up of a	
		The CED indicated the		corrective action will be	•
		ne investigation could not		monitored by the Executive	
		vas able to find a signed		Director, Business Office	
		•		Manager or designee will be	
	statement from F	RA #3 who was present			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE : COMPL 07/28 /	ETED
	PROVIDER OR SUPPLIER		72 ⁻	12 US	DDRESS, CITY, STATE, ZIP CODE HWY 31 S APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	provided a copy statement dated RA #3 indicated grabbing the fore pulling Resident RA #3 indicated not to touch the Resident #B left reported the incistatement indicated checked on the reshowed the staff grabbed the arm During an interv 7/28/14 at 1:45 p RA #3 had reported the indicated checked on the resident #B and RA #4 indicated checked on the resident, Resident the AD had grab resident. RA #4 reported the information Multiple attempt unsuccessful. Ref/18/14. As of 7 for RA #3 lacked training for abus reporting.	iew with RA #4 on o.m., RA #4 indicated ted an incident involving the AD to her on 7/1/14. when she and RA #3 esident shortly after the int #B reported to her that bed the arm of the indicated she then indicated she indicated she then indica			responsible for monitoring the timely completion of orientation. 5 To ensure continued compliance an ongoing annual in service will be conducted the Ombudsman and over set by the Administrator 6. The date the systemic change will be completed by is Augus 31, 2014.	ıal by en es	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 07/28	LETED
	PROVIDER OR SUPPLIER		7212 US	NDDRESS, CITY, STATE, ZIP COD S HWY 31 S APOLIS, IN 46227	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	worked for the A hours worked in 7/1, 7/2, 7/3, 7/7 7/13, 7/14, 7/15, The timesheet in out 2:27 p.m., 4 received from th Resident #B indiphysically abuse On 7/23/14 at 11 Director provide Resident's Right Facility and indione currently use of the document Residents have t(2) physical ab	:10 a.m., the Marketing d a copy of an undated s Residential Care cated the policy was the ed by the facility. Page x indicated, "(v) he right to be free from: buse; (3) mental abuse"				
R000090	overall manageme responsibilities of include, but are no (1) Informing the o	· · · · · · · · · · · · · · · · · · ·				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 6 of 71

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	DDIC	00	COMPL	ETED
			A. BUI. B. WIN	LDING		07/28/	2014
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	₹					
COLINITE	N CHADNA VIII A C				S HWY 31 S		
COUNTR	RY CHARM VILLAG	PE .		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	occurrence that d	irectly threatens the					
		health of a resident.					
		occurrence may be made					
		owed by a written report, or					
		t only that is faxed or sent					
	_	to the division within the					
		our time period. Unusual					
		de, but are not limited to:					
	(A) epidemic outb	reaks;					
	(B)poisonings;						
	(C) fires; or (D) major acciden	te.					
		not be reached, a call shall					
		nergency telephone					
	number published						
	•	nging for or assisting with					
		edical, dental, podiatry, or					
	•	her health care services as					
	_	resident or resident's legal					
	representative.						
		ctor approval prior to the					
		ndividual under eighteen					
	(18) years of age	to an adult facility.					
	(4) Ensuring the fa	acility maintains, on the					
	premises, an accu	urate record of actual time					
	worked that indica						
	(A) employee's fu						
	` '	irs worked during the past					
	twelve (12) month						
		sults of the most recent					
	-	the facility conducted by					
		iny plan of correction in					
	· ·	t to the facility, and any					
		eys. The results must be nination in the facility in a					
		essible to residents and a					
	notice posted of the						
		ports of surveys conducted					
		each facility for a period of					
		making the reports					
		ection to any member of					
	the public upon re						
		•					

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 7 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WING			07/28/2	2014
			B. 1711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			S HWY 31 S		
COUNTE	RY CHARM VILLAG	:F			APOLIS, IN 46227		
	_				1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		ew and record review,	ROO	0090	R 090 – Administration and		08/31/2014
	the facility failed	d to ensure the division			Management - Deficiency 1. The corrective action(s) that has		
	was notified with	hin 24 hours of becoming			been accomplished for Reside		
	aware of a repor	ted staff to resident			B was employee identified by		
	physical abuse o	occurrence for 1 of 8			Resident B is no longer emplo	ved	
	1 ~ -	ed for abuse. (Resident			at Country Charm Village.		
	#B)	Tar doubt. (Hobidoni			Executive Director followed up)	
	# D)				with Resident B to determine i		
	 				any further action was required		
	Findings include) :			Resident B stated she is fine		
	The clinical record of Resident #B was reviewed on 7/23/14, at 1:05 p.m.				long as the identified employed was not going to assist her	e	
					anymore. 2. The facility		
					reviewed each resident's reco	rd	
	Diagnoses include	ded, but were not limited			and determined all residents	. ~	
	to, hypertension.	, Alzheimer's disease,			could be affected by the allege	ed	
	. –	blindness in the left eye.			deficient practice and all		
	,				employees were trained how		
	During an interv	riew with Resident #B on			report similar incidents to ISD0	OH	
	_				and the Executive Director designated the DON to make		
	_	o.m., Resident #B			such reports in her absence.	3	
	_ ^	ployee had, "grabbed my			The measures that will be put		
	arm hard" while				into place and the systemic		
	attempting to he	lp the employee.			changes the facility will make t	to	
	Resident #B ind	icated the employee said			ensure that the deficient practi	ce	
	something to the	e resident as well, but			does not recur include the	.	
	could not remen	ber exactly what was			Executive Director self-study a	ina	
	said. Resident #	B indicated the incident,			discussions with her management team on the		
		s" and the resident			reporting requirements and		
		esident's apartment.			procedures identified in this		
		icated another staff			deficiency. The Executive		
					Director, after completing her		
	_	esent when the incident			study and discussions with the	•	
		staff members had			management team shall	toff	
		resident shortly after the			in-service and re-educate all s regarding the reporting	lall	
	incident.				requirements associated with		
					physical, sexual and mental		
	During an interv	riew with the Corporate			abuse. This topic will also be		
	1	*	1		I '		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL OO COMPLETED 07/28/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227 (X5) PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED 07/28/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE 7212 US HWY 31 S INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
COUNTRY CHARM VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLETION) (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION	
PREFIX (FACH DEFICIENCY MIIST RE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO) CROSS-REFERENCE TO THE APPROPRIATE COMPLETION	
	1
TAG REGULATOR OR ESCIDENTIFIEND INFORMATION) TAG	
evicate to the chall include the	
Director of Nursing (DoN) on 7/24/14 at	
3:00 p.m., the CED indicated the facility investigation and provide the	
was in the process of investigating an ISDOH with the follow up report	
incident/allegation of physical abuse of findings within five (5) days thereof. 4. The Executive	
Director shall monitor daily all	
indicated a family member of Resident incident reports to ensure the	
#B had faxed a concern to the facility reporting is made to the State on	
regarding an incident with the Activity Director and Posident #P. The CED DON shall monitor the incident	
Priector and Resident #B. The CED	
indicated the facility had a new Executive 5 To ensure continued	
Director (ED) and the ED had initiated compliance an ongoing annual in	
the investigation and filed a report when service will be conducted by the	
the fax was received on 7/21/14. Ombudsman and overseen by the Administrator. 6. The date the	
systemic changes will be	
During the interview on 7/24/14 at 3:00 completed by is August 31, 2014	
p.m., the DoN indicated Resident	
Assistant (RA) #4 had reported an	
incident to her on 7/1/14, that involved	
the AD and Resident #B. The DoN	
indicated RA #4 had informed her of	
Resident #B becoming upset, because the	
AD had grabbed the arm of the resident.	
The DoN indicated Resident #B was	
upset about the incident, but had no	
visible injuries. The DoN indicated she	
had checked on Resident #B and then had	
informed the ED of the incident. The	
DoN indicated she did not think the	
former ED had reported the incident to	
the Indiana State Board of Health	
(ISDH).	
During an interview with the CED on	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
			B. WING		07/28	/2014
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE		
				US HWY 31 S		
COUNTR	RY CHARM VILLAG	E	INDIA	NAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE PRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	_	o.m., the CED indicated				
	_	rith the former ED				
	1 ~ ~	eident with Resident #B,				
		ED indicated the incident				
	_	usly investigated and was				
		o have been a situation				
		and a report was not				
	filed with ISDH	. The CED indicated the				
	_	ne investigation could not				
	be located, but v	vas able to find a signed				
	statement from I	RA #3 who was present				
	at the time of the	e incident. The CED				
	provided a copy	of the handwritten				
	statement dated	7/1/14. In the statement,				
	RA #3 indicated	the AD was observed				
	grabbing the for	earm of Resident #B and				
	pulling Resident	#B towards the door.				
	RA #3 indicated	Resident #B told the AD				
	not to touch the	resident and then				
	Resident #B left	the room. RA #3 then				
	reported the inci	dent to RA #4. The				
	statement indica	ted RA #3 and RA #4				
	checked on the r	resident, and Resident #B				
	showed the staff	how the AD had				
	grabbed the arm	of the resident.				
	During an interv	riew with RA #4 on				
	7/28/14 at 1:45 p	o.m., RA #4 indicated				
	RA #3 had repor	rted an incident involving				
	_	the AD to her on $7/1/14$.				
	RA #4 indicated	when she and RA #3				
	checked on the r	resident shortly after the				
		nt #B reported to her that				
		bed the arm of the				
	I S		1	Ī		I

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 10 of 71

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 07/28	
	PROVIDER OR SUPPLIER RY CHARM VILLAGE	STREET A 7212 US	ADDRESS, CITY, STATE, ZIP COI S HWY 31 S APOLIS, IN 46227	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	resident. RA #4 indicated she then reported the information to the DoN.				
	Multiple attempts to contact RA #3 were unsuccessful. RA #3 was hired on 6/18/14. As of 7/28/14, the employee file for RA #3 lacked documentation of training for abuse prevention or reporting. On 7/28/14 at 10:10 a.m., the ED provided copies of hours and days worked for the AD. A review of the hours worked indicated the AD worked 7/1, 7/2, 7/3, 7/7, 7/8, 7/9, 7/11, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, and 7/21/14. The timesheet indicated the AD clocked out 2:27 p.m., 4 hours after the fax was received from the family member of Resident #B indicating the AD had physically abused the resident. On 7/23/14 at 11:10 a.m., the Marketing Director provided a copy of an undated Resident's Rights Residential Care Facility and indicated the policy was the one currently used by the facility. Page x of the document indicated, "(v) Residents have the right to be free from:(2) physical abuse; (3) mental abuse" This state residential tag relates to Complaint IN00152777.				
	received from the family member of Resident #B indicating the AD had physically abused the resident. On 7/23/14 at 11:10 a.m., the Marketing Director provided a copy of an undated Resident's Rights Residential Care Facility and indicated the policy was the one currently used by the facility. Page x of the document indicated, "(v) Residents have the right to be free from:(2) physical abuse; (3) mental abuse" This state residential tag relates to				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 11 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/28/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			S HWY 31 S	
COUNTR	Y CHARM VILLAG	E		APOLIS, IN 46227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000092	410 IAC 16.2-5-1.3 Administration and Noncompliance (i) The facility must and disaster preparation and disaster preparations are continuity of care of emergency as follows: (1) Fire exit drills in transmission of a facility of emergency as the suilding is not conducted quarter familiarize all facility and emergency are conditions. At least held every year. We between 9 p.m. and announcement material and emergency are conditions. (2) At least every shall attempt to he drill in conjunction department. A receive shall be document signatures of the propagation o	It maintain a written fire aredness plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, ovement of nonambulatory areas or to the exterior of required. Drills shall be ly on each shift to ty personnel with signals of the drills are conducted at twelve (12) drills shall be when drills are conducted and 6 a.m., a coded as be used instead of lists (6) months, a facility old the fire and disaster with the local fire ord of all training and drills are dwith the names and personnel present. It to ensure fire drills quarterly on each shift. The ential to affect 53 aside in the facility.	R000092	R 092 – Administration and Management - Noncompliant 1. All residents were alleged affected by this deficiency and corrective action to be accomplished is described believed and 3. To ensure all residents are no longer at risk	O8/31/2014 O8/31/2014 OW.
	Findings include	:		be affected by this deficiency a the measures that will be put in	and

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 12 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMP	COMPLETED	
A. BUILDING	8/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
7212 US HWY 31 S		
COUNTRY CHARM VILLAGE INDIANAPOLIS, IN 46227		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
Review of Country Charm Village place and the systemic changes		
Management Fire Drill documentation on the facility will make to ensure		
7/23/14 at 11:45 a.m. the facility leaked that the deficient practice does		
not recul include the Executive		
documentation of an implemented fire Director, in coordination with the		
drill for third shift (nights) for the second facility maintenance director, creating a policy and an in-service		
quarter of 2014. They facked the		
documentation of an implemented second completion of facility fire drills and		
shift (evening) fire drill for first quarter disaster preparedness. The		
and second quarter of 2014. They lacked Executive Director along with the		
the documentation of an implemented maintenance director shall		
fire drill for first shift (day) for the first		
lacility disaster preparedness		
quarter of 2014. plan, including making contact		
with the local fire department to conduct to not only the required		
Interview with Administrator on 7/28/14 Conduct to not only the required fire drills therein, but to review the		
at 1:50 p.m., indicated that they did not role of the fire department and		
have documentation of the missing fire other para-medic agencies the		
drills or where they had tried to set up a response time and instructions for		
fire drill with the local fire department. other potential disasters.		
He continued to indicate the facility had Quarterly fire drills will be		
Conducted on each shift and		
provided all the documentation on the include a schedule to ensure a		
fire drills they had. quarterly fire drill 4. The Executive Director shall monitor		
monthly for compliance. A		
In an interview with the Corporate quarterly fire drill was completed		
Executive Director on 7/25/14 at 11:25 7/31/14 for residents and staff of		
a.m., indicated that the facility could not each shift, and the maintenance		
locate a fire drill policy. director is instructed to perform at		
least twelve (12) drills each year,		
including the recording of training		
On 7/25/14 at 11:25 a.m., the Corporate performed, and the documented		
Executive Director provided the Fire names and signatures of staff present. 5. The date the		
Diffi i roccdure and indicated this		
procedure was the one currently being completed by is August 31, 2014.		
used by the facility. The fire drill		
procedure indicated at the end of a fire		
drill to, " Complete the Fire Drill		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2014		
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
R000116	participants signal complete give to signature." 410 IAC 16.2-5-1.4 Personnel - Nonco (a) Each facility ship procedures written screening of prosp. Appropriate inquiri prospective employ have a personnel references and an accordance with IC Based on record the facility failed that 4 of 9 employ lacked document (Certified Nurse (License Nurse #Findings include Review of employ 10:00 a.m., 4 of 9 reviewed lacked references. 1.) Certified Nurse (License Nurse #Findings include Review of employ 10:00 a.m., 4 of 9 reviewed lacked references.	ompliance hall have specific hand implemented for the hective employees. hes shall be made for hyees. The facility shall hepolicy that considers hy convictions in high 16-28-13-3. hereview and interview, had to check references in hyee files reviewed heation for references. hide # 9, #20, & #34) heating the formula of t	R000116	R 116 – Personnel - Noncompliance 1. The Community completed the reference checks on Certified Nurse Aides 9. 20 and 34 and License Nurse 41, 2. The Executive Director and facility business office personnel sha review the facility new hire che list of requirements, including completion of all prospective employee reference checks fo current employees to ensure t all reference checks are completed and documented a available in the employee personnel file. 3. The measures that will be put into place and the systemic chang the facility will make to ensure	II eck the or all hat	
	references being	completed.		that the deficient practice does		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/28/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE		
	05/19/14, had no references being 3.) License Nurse 06/03/14, had no references being 4.) License Nurse 07/03/14, had no references being Interview with the 07/28/14 at 1:50 facility had provide documentation the unable to locate to	e # 34, hire date of documentation of completed. e # 41, hire date of documentation of completed. e Administrator on p.m., indicated the		not recur is the business office manager has been in-serviced with the new employee hire ch list of requirements before theis start of work date. Department heads are instructed and a poldrafted that any potential new is not eligible to work or begin work shift until all new hire personnel requirements are complete. 4. The Executive Director shall monitor monthly compliance. 5. The date the systemic changes will be completed by is August 31, 20	leck ir ic licy hire a		
R000119	Personnel - Nonco (d) Prior to working employee shall be facility by the supe designee) of the de employee will work	g independently, each given an orientation to the rvisor (or his or her epartment in which the k. Orientation of all clude the following: the needs of the					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/28/2014	
NAME OF DROUBLED OR GURDINED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	L	7212 U	IS HWY 31 S		
COUNTR	RY CHARM VILLAG	E	INDIANAPOLIS, IN 46227			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	and applicable pro (A) organization o (B) personnel poli (C) appearance al employees; and (D) residents' righ (3) Instruction in fi procedures, and fi preparedness, inc procedures. (4) Review of ethic confidentiality in re (5) For direct care introduction to, an particular needs o the employee will (6) Documentation employee's perso supervising the or Based on intervi the facility failed documentation of 9 employee fi prior to working employee's file I indicated having which included: rights, general jo	e facility's policy manual ocedures, including: hart; cies; and grooming policies for ts. rst aid, emergency re and disaster luding evacuation cal considerations and esident care and records. staff, personal distruction in, the feach resident to whom be providing care. In of the orientation in the nnel record by the person ientation. ew and record review, all to provide of initial orientation for 4 les reviewed in that independently the acked documentation to received orientation a review of resident's ob description and abuse fied Nurse Aide #9, #20, Nurse # 41)	R000119	R 119 – Personnel - Noncompliance 1. Employees 9, 20, 34, and 41 receiving initial orientation, a review of resident's rights, general job description and at training before working with residents received training an orientation. The policy for suc was made available to these employees and put in a place where access is readily availaduring a survey and for all management and employees. 2. The Executive Director, allowith the Business Office Director.	buse d h ble	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
						07/28/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
COLINITE	N/ OLIA DAA VIII I. A O	·F			S HWY 31 S		
COUNTR	COUNTRY CHARM VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
					and specific department heads shall review all existing person		
	Review of emplo	oyee files on 7/24/14 at			files to insure that any current	IIIEI	
	10:00 a.m., indic	cated 4 of 9 employees			employee who has not comple	ted	
	did not receive in	nitial orientation, a			the required orientation, nor ha		
	review of reside	nt's rights, general job			signed job description, comple		
		abuse training before			therein. 3. The Executive		
	_	n working with residents.			Director shall create a new hire		
	employees began	ii working with residents.			Orientation program to provide and insure that all new hire)	
	1) Certified Nur	rse Aide #09, hire date of			employees are aware, informe	d.	
	· '	o documentation of			and knowledgeable regarding	,	
	· ·				many of the facilities rules,		
	-	orientation, a review of			policies, and guidelines, includ	ling	
		general job description			residents' rights, fire drills,		
		ng. Review of current			disaster preparedness, and		
	CNA Schedule,	July 13- July 26,2014;			resident abuse training. The Executive or designee shall		
	indicated CNA #	#09 remained actively			conduct an orientation with all		
	working with res	sidents.			new hires prior to working		
	_				independently. The orientation	ı	
	2.) Certified Nu	rse Aide #20, hire date of			shall include: review of the		
	· 1	documentation of			employee handbook and facilit	-	
		orientation, a review of			policy and applicable procedur	es,	
	_				first aid and emergency procedures, fire and disaster		
		general job description			procedures, life and disaster preparedness, evacuation		
		ng. Review of current			procedures; HIPPA regulations	S	
		July 13- July 26, 2014;			and resident rights and privacy		
		‡20 remained actively			and other information relevant		
	working with res	sidents			the position of the new hire. The	nis	
					shall include instruction for a		
	3.) Licensed Nur	rse #34, hire date of			specialized population to inclu		
		documentation of			aging, memory, and dementia. The Executive Director shall	•	
	· ·	orientation, a review of			review the new orientation		
	_				worksheet to insure		
	resident's rights, general job description and abuse training. Review of current				completeness and preparedne	ess	
		hedule, July 13- July 26,			prior to the new hire working		
	· ·				independently. The Executive,		
		LPN #34 remained			along with the department hea	as,	
	actively working	g with residents			will insure that each new		

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2014
	ROVIDER OR SUPPLIER RY CHARM VILLAGE	STREET ADDRESS, CITY, S 7212 US HWY 31 S INDIANAPOLIS, IN 46	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORREC CROSS-REFEREN TAG	S PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DATE (X5) COMPLETION DATE
	4.) License Nurse #41, hire date of 07/03/14, had no documentation of receiving initial orientation, a review of resident's rights, general job description and abuse training. Review of current Nurse/ QMA Schedule, July 13- July 26, 2014; indicated LPN #41 remained actively working with residents Interview with the Administrator on 07/28/14 at 1:50 p.m., indicated the facility had provided all the documentation they had. They were unable to locate the facility's policy and procedure for completing employee files.	responsibilitie job/employm reads and sig and complet program pric and or workir The Executiv monitor monit 4. The Execut monitor complate the syst	the duties and es of their ent description; gns receipt thereof, es the orientation or to the start of work ng independently. ee Director shall thly for compliance. utive Director shall
R000121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read,		

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	
			B. WIN	G		07/28/	2014
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	ę.		7212 US	S HWY 31 S		
COUNTR	RY CHARM VILLAG	Ε		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and by whom adm	ninistered. The facility must					
	assure the following						
	` '	employment, or within one					
		employment, and at least					
	-	er, employees and nonpaid ties shall be screened for					
	•	first tuberculin skin test					
		r to the employee starting					
	·	care workers who have not					
		d negative tuberculin skin					
		the preceding twelve (12)					
		ine tuberculin skin testing					
		e two-step method. If the					
	first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat						
	·	d on the risk of infection					
	with tuberculosis.	d on the risk of infection					
		who have a positive					
		n test shall be required to					
	have a chest x-ray	y and other physical and					
	laboratory examin a diagnosis.	ations in order to complete					
	-	all maintain a health record					
		that includes reports of all					
		ed health screenings.					
	` ' '	with symptoms or signs of					
		ymptoms suggestive of					
		s, including, but not limited					
		night sweats, and weight permitted to work until					
	tuberculosis is rule	<u> </u>					
		ew and record review,	R00	0121			08/31/2014
		d to ensure 5 of 9	1100	V.2.	R 121 - Personnel -		00/01/2011
	1				Noncompliance		
		reviewed received a					
	•	th Screening prior to			1. Employees 9, 20, 34, 41, a		
		with the residents.			12 have had their health scree	ens	
	(Certified Nurse	Aide #9, #20, & #34)			completed.		
	(License Nurse #	#41) (Dietary aide #12)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		COMPLETED		
				B. WING			2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
COLINITE		· F			S HWY 31 S		
COUNTRY CHARM VILLAGE				INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	2:			The Business Office Direct		
					shall review all current employ		
	Review of emplo	oyee files on 7/24/14 at			personnel files to determine a	ny	
	_	cated 5 of 9 employees			employee who is missing the		
					required health assessment screen and tuberculin skin tes		
		ealth screening done.			Nursing department shall initia		
	1	ed to acquire a completed			any missing skin test, and reco		
	_	before employees began			in the respective employee file		
	working with res	sidents.					
	1.) Certified Nu	rse Aide #09, hire date of					
	06/18/14, had no documentation of a				3. A new hire policy was crea		
	health screen. Review of current CNA Schedule, July 13 - July 26, 2014;				that requires the proper screei	ning	
					to include the following: TB		
					testing, background check, excluded party check, physica		
	indicated CNA #	#09 remained actively			health approval, drug test prio		
	working.				hire and resident contact, and		
					offender check. The Business	OOX	
	2.) Certified Nu	rse Aide #20, hire date of			Office Director shall utilize the		
	· ·	documentation of a			new employee hire requirement	nts	
	· ·	Review of current CNA			checklist to monitor and record		
					new hire employee documents	6,	
		3 - July 26, 2014;			including the checklist for the		
		#20 remained actively			signature of the Executive	tort	
	working with res	sidents.			Director for approval, prior to sof work date.	olari	
	3.) License Nur	se #34, hire date of					
		o documentation of a					
		Review of current			4. The Director of Nursing sha	II	
		nedule, July 13 - July 26,			be responsible for the monitor		
	`				the completion of all new hire		
	ĺ í	LPN #34 remained			health screens.		
	actively working	7 .					
	4.) License Nurs	se #41, hire date of			5. The date the systemic		
	07/03/14, had no	o documentation of a			5. The date the systemic changes will be completed by is		
	· ·	Review of current			August 31, 2014.		
		nedule, July 13 - July 26,]		
	Truisc/QIVIA SCI	icauic, july 13 - july 20,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/28/2014			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
		LPN #41 remained					
	health screen. R work schedule, J indicated Dietary actively working Interview with the 07/28/14 at 1:50 facility had provide documentation the	documentation of a seview of current dietary uly 13 - July 26, 2014; Aide #12 remained with residents. The Administrator on p.m., indicated the ided all the ney had. It was not done but they were moving					
R000144	(a) The facility sha a state of good rep and shall provide r residents. Based on observa facility failed to p services necessar orderly, and com	ety Standards - Deficiency Il be clean, orderly, and in pair, both inside and out, reasonable comfort for all ration and interview, the provide housekeeping ry to maintain a sanitary, fortable interior. This to affect 53 of 53 g in the facility.	R000144	R 144 – Sanitation and Safet Standards - Deficiency 1. All residents were allege affected by this deficiency and corrective action to be accomplished is described be In addition, the Executive	edly d the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPL	ETED
			B. WING	.10		07/28/	2014
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			S HWY 31 S		
COUNTRY CHARM VILLAGE					APOLIS, IN 46227		
COUNT	CI CHARW VILLAG		II'	NDIAINA	AFOLIS, IN 40221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	On 7-23-14 at 2:	25 p.m., the following			Director shall instruct		
	was observed:				housekeeping that soiled area		
					near resident room # 24 is		
	1) Near resident	t room 24 there was a			thoroughly cleaned. The Executive Director shall monitor		
	· 1	abstance dried on the			on a weekly basis to ensure	וכ	
					compliance. The Executive		
	wall and baseboa	ard.			Director has instructed		
					housekeeping to perform a dec	ер	
	2.) Through out	the facility hallways,			cleaning of the hallway handra		
	handrails are loc	ated on the walls. The			areas behind thereof, and to		
	handrails had an	approximate 2 inch			maintain a part of the regular		
					cleaning schedule.		
	groove between the outer surface and the wall. The grooves of the handrails were						
	1	with dirt, trash, debris,			The Executive Director has als		
	deceased insects	, food particles, and half			scheduled the resident laundry		
	a medication cap	osule.			a complete cleaning of the floor		
					pipes, lights, and sprinkler hea		
	3.) In the resider	nt laundry room an			along with the removal of	,	
	*	d brown splattered spill			wallpaper, and painting for		
	_	niddle of the board to the			8/12/14. This shall include the	;	
					purchasing of a new ironing bo	oard	
		ance of the laundry room,			and or cover.		
	_	er and spill stains on the					
	wall, cobwebs be	ehind the ironing boards,					
	and the walls thr	oughout the laundry			The corridor wall near room #4	15	
	room had areas t	the drywall was damaged,			and extending the balance of t		
		d nicked and gouged			hallway thru resident room # 6		
	_	paper boarder close to the			scheduled for complete painting		
	_	· -			the week of 8/11/14. This	<u> </u>	
	ceiling was detached and frayed around				includes the cleaning of cobwe	ebs,	
		eter of the room. The			and other dirt and debris. This		
	hardware attaching a detergent dispenser to the wall was mounted, but the actual dispenser was gone. The hand sink that				includes cleaning the door jam	ıb	
					near resident room #47. The		
					vent also near the mechanical		
		ion was located at lacked			room shall be cleaned 8/11/14	•	
	1 -	vash solution. The pipes					
		the hand sink had an					
	located belieath	HIC HAIIU SIIIK HAU AH					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 07/28 /	ETED
	PROVIDER OR SUPPLIER			7212 US	DDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	The floor tiles up loose and raised. floor was covered debris. The spring with a white subbe a dryer sheet. pulled away from was overflowing had began to account of the was for the wallpaper sides of the door 5.) There were considered.	r next to resident room was missing on both			The carpet in resident room # shall be deep cleaned the wee of 8/18/14. New carpet shall be purchased and installed if the E.D. determines that the carped does not come clean. Housekeeping and Executive Director shall monitor for cleanness thereafter. Also, the fans and light fixtures in activit room were cleaned 7/31/14. Housekeeping has also been instructed to clean and sanitize community water fountains. Because of the age of the physical fountain equipment; if cannot be completely clean to Executive Director satisfaction the actual drinking fountains sl be removed, the walls repaired and repainted.	ek ee et y ee all the nall	
	had an accumula 7.) The vent local room had an accumula and debris. 8.) In resident rosoiled and staine 9) The ceiling fa	n blades in the activity substance, thick			2 and 3. To ensure all reside are no longer at risk to be affected by this deficiency and measures that will be put in pla and the systemic changes the facility will make to ensure that the deficient practice does not recur include the Executive Director, along with the Maintenance and Housekeepin director have created daily assignment sheets to review, monitor and evaluate certain facility cleaning, sanitation and safety issues. Housekeeping shall be provided with in-service for resident room cleaning and resident common areas.	the ace	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	ETED
			B. WING	-		07/28/	2014
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			S HWY 31 S		
COUNTR	Y CHARM VILLAG	E			APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	10) The water dr	rinking fountain located			Housekeeping is instructed wh	iich	
	near the resident	living room was cover			items to clean, how to clean,		
		tion of a white substance			chemicals appropriate to use to		
		ubstance on the water			insure proper cleaning results. Housekeeping has also been		
	spout and top of				in-serviced on all the deficient		
	spout and top of	the fountain.			practices as presented in the		
	11) 771				alleged deficiency and address	sed	
		rinking fountain located	1		above in number 1. Daily clear		
		room 54 was cover with			assignment sheet are provided	t	
	a accumulation of	of a white substance and			and returned to the Executive		
	blue/green subst	ance on the water spout			Director for daily inspection an		
	and top of the fo	untain.			compliance which shall include the identified items in the	9	
	•				deficiency as well as items		
	12) The water dr	rinking fountain located			observed during the Executive		
		room 58 was cover with			Director's daily rounds.		
				2			
		of a white substance and					
	<u>-</u>	ance on the water spout					
	and top of the fo	untain.			4. The Executive Director or		
					designee shall make rounds do	-	
	13) The water dr	rinking fountain located			to monitor the cleanliness of the building common and commun		
	near the resident	room 6 was cover with a			areas, sample 5 resident room	-	
		a white substance and			daily, and insure that		
		ance on the water spout			housekeeping and maintenand	e l	
	_				issues are addressed, monitor		
	and top of the fo	untain.			and resolved before the end of	f	
					shift. The Executive Director o	r	
					designee shall review daily		
					cleaning assignment sheets fo	r	
					compliance.		
			1				
			1				
			1		5. The date the systemic		
					changes will be completed by	is	
					September 10, 2014.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLE		(X3) DATE SURVEY COMPLETED 07/28/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
R000148	(e) The facility sha grounds, and equicondition, in good that may adversel welfare of the resi follows: (1) Each facility shimplement a writter maintenance to errupkeep of the faci (2) The electrical sappliances, cords, sources, fire alarm shall be maintaine functioning and concept electrical codes. (3) All plumbing shomply with state (4) At least yearly, systems shall be in Based on record the facility failed was free of haza health of residentheating and ventinspected yearly to affect 53 residently. Findings included During environm 2:25 p.m. the following in the living and the living in the living included the living in the living included the living inc	fety Standards - Deficiency all maintain buildings, pment in a clean repair, and free of hazards y affect the health and dents or the public as a nall establish and en program for asure the continued lity. System, including switches, alternate power and detection systems, and to guarantee safe ampliance with state anall function properly and plumbing codes. The health and the public and the ilating systems were. This had the potential dents who reside in the	R000148	R 148 – Sanitation and Safe Standards - Deficiency 1 a 2. All residents were allegedl affected by this deficiency and corrective action to be accomplished will be the Executive Director and Maintenance Director have (8/4/14) re-keyed, locked and secured the common are stor closed. Each resident room si be re-keyed with locked and secured storage cabinets for personal items, and safe and secure from other residents. The Housekeeping and Other specific and related departme shall receive an in-service regarding chemicals used, an the appropriate and safe way	and y d the age hall 3. ints	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		07/28/2014
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	R		JS HWY 31 S	
COUNTR	RY CHARM VILLAG	E		NAPOLIS, IN 46227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		artially open. There was		use, store, and protect chemic and cleaning agents in	cais
		sanitizer with a warning		safeguarding the residents fro	m
	1	le, keep out of reach of		obtaining, touching or	
		use in eye, if swallowed		swallowing. This in service wi	I be
		lp/ contact poison		conducted upon hire of new employees with documentation	n
	control."			placed in the employee file.	
				Executive Director shall instru	
	l '	also, three 1.8 ounces		that the Maintenance Director	
cans of aerosol spray with a warning label, "flammable, keep out of reach of children, may cause eye irritation, if			work with an outside HVAC	40	
			contractor and vendor to initia and perform and annual syste		
			and equipment inspection. Th		
	inhaled may be harmful, or fatal. Keep			was completed the week of	
	away from sunli	ght, remove cap and		8/4/14. The Executive Director	
	install only in au	itomatic dispenser units		and Maintenance Director sha create a preventative	
	which is position	ned so that the		maintenance schedule to insu	re
	concentrated spr	ray will not hit people,		that the equipment and fixture	
	animals, food, di	rinks, food processing		are properly serviced and	
	surface, keep car	n at least 8 ft away from		maintained. 4. The Execut Director shall review and mon	
	exposed food."			monthly for compliance. 5.	itoi
				The date the systemic change	es
	On 7/23/14 Hou	sekeeping Director		will be completed by is Augus	t 15,
	indicated that the	e facility no longer used		2014.	
	aerosol spray dis	spensers in the secured			
	unit.				
	1c) In the living	room in the secured unit,			
	'	ind the entrance door was			
		fred bull and an empty			
		f with books and games			
	_	garden tools (a shovel			
	· `	rake). Also located on			
		vo 16 oz. bottles of hand			
		ing label, "keep out of			
	reach of children				
	150011 OI CIIIIGICI	1.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 07/28/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Nursing indicate items had the positive ambulatory residutilizing the living the secure Alzher. 2) On 7/28/14 at with Maintenance conducted he incompleted in the secure Alzher. 2) On 7/28/14 at 1:: Administrator in documentation of	dicated, that he could not entation of the heating system being inspected. 50 p.m., the					
R000154	(k) The facility sha kitchen areas, con equipment, and ut litter and rubbish, repair in accordan Based on observ	5(k) fety Standards - Deficiency ll keep all kitchens, nmon dining areas, ensils clean, free from and maintained in good ce with 410 IAC 7-24. ation and interview, the keep all kitchens and	R000154	R 154 – Sanitation and Safe Standards - Deficiency 1, and 3. All residents were	=	08/31/2014	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
			B. WIN			07/28/	2014
			В. WII.	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			S HWY 31 S		
COUNTR	RY CHARM VILLAG	E			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	kitchen areas cle	ean, maintained, and in			allegedly affected by this		
	good repair. The	is had the potential to			deficiency and the corrective		
	affect 53 of 53 re	esidents, who ate food			action to be accomplished will		
	prepared in the k				the Executive Director, Dietary Manager, Maintenance and	′	
	prepared in the r	Attenen.			Housekeeping shall create and	۱ ا	
	Pin 4in in .1 .4.				review a schedule and	1	
	Findings include	2 .			assignment sheet to insure all		
					equipment, floors and space w		
		n tour with the Dietary			the dietary and serving areas a	are	
	Manager on 07-2	23-14 at 10:10 a.m., with			kept clean, neat and needed		
the following observed:				repairs resolved. The kitche floor drain shall be cleaned an			
				painted, the ceiling vents clear	-		
	1) In the kitchen the floor drain located				the walls in the dietary serving		
	between the stove and steamer was				area painted, and certain door		
		ng/missing paint, and			frames within the kitchen area		
	rusty.	ng/mssmg pame, and			shall be painted. The respecti		
	Tusty.				departments shall work togeth	er	
	2) TI 11:	. 1 . 1 1 . 1			to insure certain weekly, and		
	_	ents located above the			monthly cleanings and maintenance. The Executiv	ا م	
		area, in dry food storage			Director and Dietary manager	Ĭ	
	room, and over o				shall create a preventive		
	dishmachine, we	ere soiled with			maintenance and cleaning		
	accumulation of	dirt and dust extending			schedule to insure work and		
	to the ceiling.				serving spaces are clean, near	t	
					and orderly; including the identification of certain items a	nd	
	3) The door fran	ne going into the dish			spaces in need of repair,	iiu	
	machine is soile	d with dirt, stains, has			maintenance or replacement.		
		and missing paint.			4. The Executive Director shal	ı	
					review and monitor monthly fo		
	4) In the steam t	able room the area near			compliance. 5. The date the	9	
	·	had accumulation of			systemic changes will be completed by August 31, 2014		
					Completed by August 31, 2014	٠.	
		platter/spill stains and					
	gouged areas on	the wall.					
	5) Ceiling vents						
	refrigerator and	the ice machine was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/28/2014	
			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		7212 U	S HWY 31 S		
COUNTR	Y CHARM VILLAG	E	INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		lust extending to the				
	ceiling					
	6) The floor drain	n cover located near the				
	ice machine was	soiled with dirt and				
	debris, had peelin	ng/missing paint, and				
	rust.					
	During an interv	view with the Dietary				
	Manager she ind	icated she agreed with				
	the above mention	oned findings, but they				
		t a maintenance director				
	for about 3 mont					
	101 400 40 5 1110110					
R000214	410 IAC 16.2-5-2(•				
	Evaluation - Defici	of the individual needs of				
		Il be initiated prior to				
	admission and shall be updated at least					
		upon a known substantial				
		dent 's condition, or more				
		nt ' s or facility ' s request. shall evaluate the nursing				
	needs of the reside	<u> </u>				
		ew and record review,	R000214	R 214 – Evaluation - Deficien	ncy 09/15/2014	
		I to evaluate the needs of		The corrective action for	33/13/2011	
	-	admission and twice a		Residents A, B, C, 60, 61, 50,	-	
	•	dmission for 8 of 8		and 18 was to ensure that goir	ıg	
		ed. (Residents #A, #B,		forward the assessments and evaluation of these residents		
		· · · · ·		needs are current and a carefu	.l	
	#C, #60, #61, #5	0, #40, and #18)		review of their past records to		
	Findings includ-			ensure nothing is missed that		
	Findings include			may not be showing up in the		
	1 The alliniant	and of Decident //D		current daily records. 2. The facility reviewed each resident		
	1. The clinical re	ecord of Resident #B was		record and determined all	ĭ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
			B. WIN			07/28/	2014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	R			S HWY 31 S		
COLINITE	RY CHARM VILLAG	. .			APOLIS, IN 46227		
				INDIAN	AFOLIS, IN 40221		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 7/2.	3/14 at 1:05 p.m.			residents could be affected by	the	
	Diagnoses include	ded, but were not limited			alleged deficient practice The	L - II	
	to, hypertension.	, Alzheimer's disease,			Executive Director and DON s	nali	
		blindness in the left eye.			review the resident listing of current residents to insure that	l all	
	depression, and	official states of the feet eye.			assessments and evaluations		
	D :1 ///D	1 14 14 1 6 114			updated and current to meet the		
		s admitted to the facility			specific resident needs for care		
		unctional evaluation was			and services. This shall also		
	completed prior	to admission. The next			include the assessment and		
	functional evalua	ation for Resident #B			evaluation of certain residents		
was completed on 7/21/14, 14 months					who may require a memory, fa	ıll,	
after Resident #B was admitted to the				or gait assessment. 3. The			
				measures that will be put into			
	facility.				place and the systemic change		
					the facility will make to ensure that the deficient practice does		
	During an interv	riew with the Director of			not recur include the DON sha		
	Nursing (DoN)	on 7/24/14 at 4:05 p.m.,			review and monitor daily nursi		
	the DoN indicate	ed the facility had			charting and communication lo		
	identified multip	ole resident assessments			to accurately identify services		
	-	which had not been			being provided, and determine	;	
	-	imely manner. The DoN			appropriate changes to the		
	-	as in the process of			service plans as warranted. The		
		•			DON shall also create a reside	ent	
		uations for all of the			list detailing assessment and evaluation dates; and dates fo	r	
	residents.				required review. The Execut		
					Director and DON shall create		
	2. The clinical re	ecord of Resident #C was			nursing QA compliance		
	reviewed on 7/2:	5/14 at 9:20 a.m.			committee, and identify certain	1	
	Diagnoses include	ded, but were not limited			items on a quarterly basis to		
	_	eart failure, high blood			monitor and review and work v		
		es, and depression.			the Corporate Quality Assuran		
	pressure, diabete	es, and depression.			Director for consult as necessary		
	D :1 :"~	1 24 10440			This shall include that the DON shall be responsible for	N	
	Resident #C was	s admitted 3/1/10.			completing a clinical record au	dit	
Resident #C had a functional evaluation				of all residents weekly for 4			
				weeks, then every other week	for		
	completed on 2/	13/13. As of 7/28/14, a			8 weeks, then monthly 3 month		
	-	functional status had not			Results will be reported and		
	-2 2 :		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/28/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			JS HWY 31 S		
	RY CHARM VILLAG		INDIANAPOLIS, IN 46227			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
	`			CROSS-REFERENCED TO THE APPROPRIA	NIE	
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	,	DATE	
PREFIX TAG	been completed been completed been completed been completed been completed been completed by the DoN indicated identified multip and evaluations are completed in a triindicated she was completing evaluations. On 7/28/14 at 2:: indicated Reside functional evaluational evaluatio	for Resident #C. iew with the Director of on 7/24/14 at 4:05 p.m., ed the facility had ale resident assessments which had not been amely manner. The DoN is in the process of nations for all of the ation completed after action completed after action completed after action completed after action ded, but were not limited ental disorder affecting ality, and reasoning), gh blood pressure), and cappetite). Service Plan for Indiana Facility for Resident #50	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	DATE Ind Ily Ing	
	semi-annual eval	on was found indicating a luation had been esident #50, since				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 07/28	
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S JAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
IAG	On 7/24/2014 at of Nursing (DoN unable to locate for Resident #50 4. Resident #61's reviewed on 7/2: Diagnoses include to, dementia (memory, personal diabetes (disorded sugars), and hyppressure). Resident #61 was Assessment and Assisted Living was completed 9 No documentation semi-annual evaluation completed for Resident #61 was completed	10:51 a.m., the Director I) indicated, she was an evaluation completed I, since 3/15/2013. Is clinical record was 3/2014 at 2:30 p.m. Ided, but were not limited Ental disorder affecting Facility, and reasoning), For causing irregular blood For examing irregular blood For each of the side of th	IAG	DEFICIENC!)		DATE
	5. Resident #60's reviewed on 7/24	s clinical record was 4/2014 at 9:10 a.m. ded, but were not limited				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 32 of 71

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2014	
	PROVIDER OR SUPPLIER		STREET A 7212 US	ADDRESS, CITY, STATE, ZIP CO S HWY 31 S APOLIS, IN 46227	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	end stage renal f	(high blood pressure), ailure (kidney failure), red blood cell count).				
	Resident #60 was admitted 7/5/2012.					
		Service Plan for Indiana Facility for Resident #60 //12/2013.				
	semi-annual eva	on was found indicating a luation had been esident #60, since				
	indicated, she wa	1:45 p.m., the DoN as unable to locate an leted for Resident #60,				
	reviewed on 7/24 Diagnoses include to, dementia (memory, personal hypertension (hi	s clinical record was 4/2014 at 11:30 a.m. ded, but were not limited ental disorder affecting ality, and reasoning), gh blood pressure), and (inflammatory bowel				
	Resident #46 wa	s admitted 3/5/2012.				
		Service Plan for Indiana Facility for Resident #46 1/25/2013.				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 33 of 71

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2014	
	PROVIDER OR SUPPLIER		STREET A 7212 US	ADDRESS, CITY, STATE, ZIP CO S HWY 31 S APOLIS, IN 46227	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	semi-annual eva	on was found indicating a luation had been esident #46, since				
	indicated, she wa	9:15 a.m., the DoN as unable to locate an leted for Resident #46,				
	reviewed on 7/24 Diagnoses include to, cerebrovascular stopped to the branch death) with left states (muscle weakness body), hypertensiand urge inconting	clinical record was 4/2014 at 2:00 p.m. ded, but were not limited lar accident (blood flow rain, causing brain cell sided hemiparesis as on one side of the sion (high blood pressure) mence (strong sudden				
	Resident #A was	s admitted 5/30/2012. Service Plan for Indiana Facility for Resident #A 1/25/2013.				
	No documentation semi-annual eva	on was found indicating a				
	On 7/28/2014 at	9:15 a.m., the DoN				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 34 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 07/28	ESURVEY LETED 8/2014	
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CO S HWY 31 S APOLIS, IN 46227	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	*	as unable to locate an leted for Resident #A,				
	indicated, the fac	5:00 p.m., the DoN cility's policy is to luation and service plan ths.				
	reviewed on 7/2: Diagnoses include to, hypertension cerebrovascular the brain is stopp death), and perm	s clinical record was 5/2014 at 1:20 p.m. ded, but were not limited (high blood pressure), accident (blood flow to bed, causing brain cell icious anemia (decrease s caused by abnormal ramin B12).				
	No documentation pre-admission evaluation for Resident #18 to the facility.	on was found indicating a valuation was completed t, prior to his admission 9:15 a.m., the DoN				
	indicated, she was pre-admission ev #18, prior to his She continued to	as unable to locate a a valuation for Resident admission on 6/30/2014. o indicate, she had aluation of Resident #18				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		AT) FROVIDENSUFFLIENCLIA IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 07/28/2014	
NAME OF P	ROVIDER OR SUPPLIER		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	Y CHARM VILLAGI	≣	7212 US HWY 31 S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
R000217	provided an untit Related Service (and indicated the used by the facili " Service Plant -Initial Resident before move-in, i Wellness Directo -Coordination of upon move-in, 30 move-in and ever as significant cha 410 IAC 16.2-5-2(e Evaluation - Defici (e) Following comp the facility, using a members, shall ide services to be prov follows: (1) The services of resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as app the resident and fa change. Either the may request a ser (3) The agreed upon	day review post ry 90 days thereafter or anges occur" e)(1-5) ency bletion of an evaluation, ppropriately trained staff entify and document the vided by the facility, as fered to the individual ppropriate to the:				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 36 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING		07/28/2014
	OF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	resident upon req (4) No identification services provided subsequent to the no need for a chan (5) If administration provision of reside both, is needed, an involved in identification of the services to Based on interviting the facility failed be provided by the residents review #C, #60, #61, #5 Findings included 1. The clinical regression included to hypertension depression, and the Resident #B was on 5/31/13. A finding completed prior #B did not have until 7/21/14, 14 #B was admitted to During an interview Nursing (DoN) of the DoN indicated the services provided to the poon indicated the services provided to the	an and documentation of is needed if evaluations initial evaluation indicate nge in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation be provided. It is document services to the facility for 8 of 8 ed. (Residents #A, #B, 0, #46 and #18) It is ecord of Resident #B was 3/14 at 1:05 p.m. Ided, but were not limited at Alzheimer's disease, blindness in the left eye. It is admitted to the facility anctional evaluation was to admission. Resident a service plan developed months after Resident	R000217	R 217 – Evaluation - Deficient 1, 2, and 3. In addition to the corrective action noted in R 2 above, the DON shall create a current resident list and reviewinsure, a complete and current service plan reflecting the resident needs and reference the assessment and evaluation. The DON shall be responsible review and complete a clinical record audit of all residents weekly for 4 weeks, then ever other week for 8 weeks, then monthly for 3 months to insurfesident service plans are current and accurate to the specific health care needs of each resident. 4. The Executive Director shall review the service plan audits.	14 a w to nt s of on. e to il ry e rrent

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 37 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2014	
		<u> </u>	B. WING		07/28/2014
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DE COMPLETION DATE
	completed in a t indicated she wa completing eval- residents, and as	which had not been imely manner. The DoN as in the process of uations for all of the the evaluations were was completing the		make report to the Quality Assurance Committee on t status of the timely comple service plans. 5. The date the systemic chan be completed by September 1	ges will
	2. The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.				
	on 2/13/13. As re-evaluation of had not been con	l a service plan developed of 7/28/14, a the needs of Resident #C mpleted and an updated not been developed.			
	Nursing (DoN) of the DoN indicate identified multipand evaluations completed in a taindicated she was completing evaluations and as	riew with the Director of on 7/24/14 at 4:05 p.m., ed the facility had ole resident assessments which had not been imely manner. The DoN as in the process of uations for all of the the evaluations were was completing the			
		30 p.m., the DoN vice plan for Resident #C			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	ECONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMI	PLETED
			B. WING	8/2014		
			_	ET ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF I	PROVIDER OR SUPPLIEF	₹		US HWY 31 S		
COUNTR	RY CHARM VILLAG	iE		ANAPOLIS, IN 46227		
	•			, 		(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE		ROPRIATE	COMPLETION
TAG		<u> </u>	TAG	DEI ICIERCI)		DATE
	had not been upo	dated since 2/13/13.				
	3. Resident #50's	s clinical record was				
	reviewed on 7/2	3/2014 at 1:00 p.m.				
	Diagnoses included, but were not limited to, dementia (mental disorder affecting					
	memory, personality, and reasoning),					
		gh blood pressure), and				
	anorexia (loss of	f appetite).				
Assessment and Service Plan for Indiana						
Assisted Living Facility for Resident #50						
	was completed of	•				
	was completed (, 13, 13, 2013.				
	No dogumentoti	on was found indicating a				
		on was found indicating a				
		been completed for				
	Resident #50, sin	nce 3/15/2013.				
	On 7/24/2014 at	10:51 a.m., the Director				
	of Nursing (DoN	N) indicated, she was				
	unable to locate	a service plan completed				
), since 3/15/2013.				
	Tor resident was	,, sines 3, 13, 2013.				
	1 Posidont #615	s clinical record was				
		3/2014 at 2:30 p.m.				
	~	ded, but were not limited				
	to, dementia (me	ental disorder affecting				
	memory, personality, and reasoning), diabetes (disorder causing irregular blood					
		ertension (high blood				
	pressure).	ortension (mgn oloou				
	pressure).					
		G : DI C : 1				
		Service Plan for Indiana				
	Assisted Living	Facility for Resident #61				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 07/28		
	ROVIDER OR SUPPLIER		STREET A 7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	was completed of No documentation service plan had Resident #61, sint On 7/28/2014 at indicated, she was service plan compared to since 9/5/2013. 5. Resident #60's reviewed on 7/24 Diagnoses include to, hypertension end stage renal for and anemia (low Assessment and Assisted Living was completed of No documentation service plan had Resident #60, sint On 7/24/2014 at indicated, she was service plan compared to since 9/12/2013.	on was found indicating a been completed for nee 9/5/2013. 11:40 a.m., the DoN as unable to locate a pleted for Resident #61, clinical record was 4/2014 at 9:10 a.m. led, but were not limited (high blood pressure), ailure (kidney failure), red blood cell count). Service Plan for Indiana Facility for Resident #60 in 9/12/2013. on was found indicating a been completed for nee 9/12/2013. 1:45 p.m., the DoN as unable to locate a pleted for Resident #60,				
	reviewed on 7/24	s clinical record was 4/2014 at 11:30 a.m. led, but were not limited				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING		07/28	3/2014
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE		
OOLINITE	N/ OLIA DAA N/II L A O	_		S HWY 31 S		
COUNTR	RY CHARM VILLAG	iE	INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIESE OF		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	,	ental disorder affecting				
		ality, and reasoning),				
	hypertension (high blood pressure), and					
		(inflammatory bowel				
	disease).					
		Service Plan for Indiana				
	Assisted Living Facility for Resident #46 was completed on 3/25/2013.					
	No documentation was found indicating a					
service plan had been completed for						
	Resident #46, since 3/25/2013.					
	On 7/28/2014 at	9:15 a.m., the DoN				
	indicated, she w	as unable to locate a				
	service plan con	npleted for Resident #46,				
	since 3/25/2013.					
	7. Resident #A's	clinical record was				
	reviewed on 7/2	4/2014 at 2:00 p.m.				
	Diagnoses inclu	ded, but were not limited				
	_	lar accident (blood flow				
		rain, causing brain cell				
		sided hemiparesis				
	· ·	ss on one side of the				
	`	sion (high blood pressure)				
		nence (strong sudden				
	_	lue to bladder spasms).				
	need to diffiate t	and to olumber opublish.				
	Assessment and	Service Plan for Indiana				
		Facility for Resident #A				
	was completed of	-				
	was completed (J11 ¬(∠J(∠U1J,				
			1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 07/28 /	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	(X5) COMPLETION DATE	
		on was found indicating a been completed for ce 4/25/2013.					
	indicated, she wa	9:15 a.m., the DoN as unable to locate a pleted for Resident #A,					
	8. Resident #18's clinical record was reviewed on 7/25/2014 at 1:20 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), cerebrovascular accident (blood flow to the brain is stopped causing brain cell death), and pernicious anemia (decrease in red blood cells caused by abnormal absorption of vitamin B12).						
		on was found indicating a been completed for ace admission.					
	On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate a service plan for Resident #18.						
	indicated, the fac	5:00 p.m., the DoN sility's policy is to uation and service planths.					
		9:00 a.m., the DoN tled section from Health					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/28/2014		
			STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	OBE COMPLETION		
	and indicated the used by the facil " Service Plant- Initial Resident before move-in, Wellness Directer -Coordination of upon move-in, 3 move-in and ever as significant characteristics. On 7/28/2014 at provided Reside undated, and indone currently use policy indicated of an evaluation facility, using apmembers, shall in	e policy was currently ity. The policy indicated, ning and Coordination assessments performed in consultation with the or as needed for service planning process 0 day review post ery 90 days thereafter or anges occur" 9:00 a.m., the DoN nt Service Plan policy, licated the policy was the ed by the facility. The propriately trained staff dentify and document the					
R000273	(f) All food prepara (excluding areas i maintained in acc	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and id safe food handling					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 07/28/2014		
	PROVIDER OR SUPPLIER			7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility failed to residing on the s prepared in kitch	ation and interview, the assure 9 of 9 residents ecure unit who ate food ten, received food	R00	00273	R 273 – Food and Nutritional Services - Deficiency		09/15/2014
	distributed and s conditions. Findings include	erved under sanitary			The alleged residents not receiving food in a sanitary manner has been corrected as described below.	S	
	During the service of noon meal on 07-24-14 at 11:05 a.m., with the following observed:				Because all residents can affected by this alleged deficiency, the Executive Dire		
	preparing deserts placed the desert #6 was observed uncovered deser- corridor of reside	nager was observed s for the secured unit and as on a cart. Dietary Staff transporting the ts on the cart down a ent rooms. The deserts and given to the residents			had the Dietary Manager immediately review and also have him/her attend a current ServeSafe food and sanitation certificate program to insure preparation, food serving, and food serving areas are maintained in accordance with state and local sanitation and safe food handling standards		
	a.m., indicated the not have left the indicated, "The shire and inservice kitchen would be	Dietary Manager at 11: 50 ne cart of deserts should kitchen uncovered. She staff was taught at time of es, anything leaving the e covered. It is my over anything leaving the			3. The dietary manager shall in-service all dietary staff on s food handling techniques, procedures and process for transporting resident food from the kitchen, dietary area to the resident eating and serving areas. All management, inclu the Executive Director, and all members of the quality assuration case they must serve reside or work in the kitchen during a	n ding l ance ning ents	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391

AND FLAN OF CORRECTION IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE INDIANAPOLIS, IN 46227 IN ORDINARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGulatory or Local Destriction of Date of Dat	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE OX-91D SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG TAG TAG TAG TAG TAG TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
NAME OF PROVIDER OS SUPPLER COUNTRY CHARM VILLAGE X-1) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The Executive Director shall request from the facilities primary food supplier a list of dietary, food preparation, food serving, and handling topics to be created as a part of the dietary in-service program. The Executive Director shall instruct the facility dietician to monitor and review such findings with the Executive Director. 4. The Executive Director and all managers will rotate and observe meals on all shifts three times weekly for the next three months. Thereafter, all managers shall observe through assigned rotation meals twice monthly. Observation reports shall be presented to the Quality Assurance Committee at their first and second quarterly meeting. 5. The date the systemic changes will be completed by September				B. WING	07/28/2014	07/28/2014	
COUNTRY CHARM VILLAGE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG EMPROPRIES PLANDE CORRECTION DATE TAG THE Executive Director shall request from the facilities primary food supplier a list of dietary, food preparation, food serving, and handling topics to be created as a part of the dietary in-service program. The Executive Director shall instruct the facility deltician to monitor and review such findings with the Executive Director. 4. The Executive Director and all managers will rotate and observe meals on all shifts three times weekly for the next three months. Thereafter, all managers shall observe through assigned rotation meals twice monthly. Observation reports shall be presented to the Quality Assurance Committee at their first and second quarterly meeting. 5. The date the systemic changes will be completed by September	NAME OF D	ROVIDER OD SHDDI IED	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
CX4) ID PREFIX CACH DEFICIENCY MINT BE PRECEDED BY FULL TAG PROVIDERS NAME CORRECTION COMPLETION	NAME OF P	KO VIDEK OK SUPPLIER		7212 U	S HWY 31 S		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The Executive Director shall request from the facilities primary food supplier a list of dietary, food preparation, food serving, and handling topics to be created as a part of the dietary in-service program. The Executive Director shall instruct the facility dietician to monitor and review such findings with the Executive Director. 4. The Executive Director and all managers will rotate and observe meals on all shifts three times weekly for the next three months. Thereafter, all managers shall observe through assigned rotation meals twice monthly. Observation reports shall be presented to the Quality Assurance Committee at their first and second quarterly meeting. 5. The date the systemic changes will be completed by September	COUNTR	Y CHARM VILLAG	E	INDIAN	IAPOLIS, IN 46227		
REGULATORY OR LSC IDENTIFYING INFORMATION) The Executive Director shall request from the facilities primary food supplier a list of dietary, food preparation, food serving, and handling topics to be created as a part of the dietary in-service program. The Executive Director shall instruct the facility dietician to monitor and review such techniques and concerns on a quarterly basis, and review such findings with the Executive Director. 4. The Executive Director and all managers will rotate and observe meals on all shifts three times weekly for the next three months. Thereafter, all managers shall observe through assigned rotation meals twice monthly. Observation reports shall be presented to the Quality Assurance Committee at their first and second quarterly meeting. 5. The date the systemic changes will be completed by September	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S BLAN OF CORRECTION	(X5)	
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Assurance Committee at their first and second quarterly meeting. 5. The date the systemic changes will be completed by September					•	e	
first and second quarterly meeting. 5. The date the systemic changes will be completed by September					1 .	_:_	
5. The date the systemic changes will be completed by September						eir	
5. The date the systemic changes will be completed by September					1		
will be completed by September					mooning.		
will be completed by September							
will be completed by September					 		
10, 2014.						mber	
					10, 2017.		
R000298 410 IAC 16.2-5-6(c)(2)	R000298						
Pharmaceutical Services - Deficiency		Pharmaceutical So	ervices - Deficiency				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 45 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/28/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.	7212 U	JS HWY 31 S		
COUNTR	RY CHARM VILLAG	E		NAPOLIS, IN 46227		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		harmacist shall be				
		er contract, and shall:				
	 (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and 					
	procedures of orde	<u> </u>				
		d disposing of drugs as				
	well as medication					
	(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and					
	(E) review the drug regimen of each resident					
		ervices at least once every				
	sixty (60) days.					
	Based on observ	ation, interview, and	R000298		09/15/2014	
	record review, th	ne facility failed to		R 298 – Pharmaceutical		
	document the red	conciliation of narcotic		Services - Deficiency		
	medications in 4	of 4 medication carts				
	and failed to ens	ure medication carts				
	remained clean f	For 2 of 4 medication		1. The corrective action as to		
	carts reviewed for	or medication storage.		Carts 1, 2, and 3, as well as the		
		2, Cart #3, and Memory		Memory Care Cart are describelow.	J e u	
	Care Cart)	, , , , , , , , , , , , , , , , , , ,		DOIOW.		
	Findings include	: :		2 and 3. This alleged deficient	CV	
				can affect all residents and the		
	1. During a review of the medication carts on 7/25/2014 from 11:20 a.m. to 12:30 p.m., the narcotic count sheets for July 2014, lacked signatures for multiple shifts, indicating narcotic counts were not			corrective action includes		
				contracting with a consultant		
				pharmacist who will review the	e	
				drug handling and storage practices in the facility; provide		
				consultation on methods and		
	completed.	, in total counts were not		procedures of ordering, storing	g,	
	completed.			administering, and disposing	-	
	o Cort #1 lool-od	Laignatures for 2 shifts		drugs. This includes methods	of	
		l signatures for 2 shifts		management, recording, and		
	on $1/2$ and $1/3/14$	4, and lacked signatures		monitoring scheduled narcotic	;	

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 46 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M				ESURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WIN			07/28/2	2014	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				S HWY 31 S			
COUNTR	RY CHARM VILLAG	E			APOLIS, IN 46227			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	on 7/4, 7/5, 7/6,	7/18, and lacked 4 of the			drugs. The pharmacist consult	ant		
	6 signatures on 7/19/14. Signatures were				shall report in writing to the			
	missing on 7/22,	7/23, 7/24, and 7/25/14.			Executive Director any irregularities in dispensing,			
	1	natures on 7/19/14,			documentation, or the			
	"	cotic count was not			administering of drugs, and			
		consecutive shifts.			review the drug regimen of each	ch		
	Completed for 3	consecutive sinits.			resident receiving these service			
	1 0 1/21 1	1			at least once every 60 days.			
		l signatures on 7/2, 7/3,						
		7/19, 7/20, and 7/23/14.						
	On 7/19/14, 3 of	the 6 signatures were			The Consulting Pharmacist an	d		
	missing.				the DON shall in-service, instru			
					and educate the nursing staff of			
	c. Cart #3 lacked	l signatures on 7/2, 7/9,			the complete use of the daily			
	7/18, 7/19, 7/20,	7/24, and 7/25. On			narcotic count sheets. The DO	N		
		6 signatures were			shall be responsible for			
	· ·	ssing signatures on			completing narcotic count medication sheet audits of all			
		ed the narcotic count was			residents with narcotic use			
	· ·	or 3 consecutive shifts.			weekly for 4 weeks, then every	,		
	not completed to	of 5 consecutive simils.			other week for 8 weeks, then			
	Managara Cana Ca				monthly for 3 months. The			
	1	art lacked signatures on			narcotic count sheet audits sha			
		0, 7/11, 7/12, 7/13, 7/16,			be reviewed with the pharmacy consultant summary reports of			
	7/18, 7/19, 7/20,	7/23, and 7/24/14.			every 60 days. The DON and			
					pharmacy consultant shall mee	et		
		iew with the Director of			and review findings, and other			
	Nursing (DoN) o	on 7/25/14 at 11:30 a.m.,			associated details with the			
	the DoN indicate	ed the nurses coming on			Executive Director.			
	shift count narcotics and sign and the nurses going off shift sign to verify the narcotic count. On 7/28/14 at 9:00 a.m., the DoN provided an undated policy,							
					The DON and Pharmacy			
					consultant shall complete a			
					schedule and listing for cleanir	ng		
					out the medication carts. The			
	_	2			DON shall create and assign the			
	"Narcotic/Contro	•			nursing schedule to review and	ا ا		
	indicated the pol	icy was the one currently			monitor with each shift			

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 47 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
			B. WING			07/28/2014	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1			
COLINITI		·F			S HWY 31 S APOLIS, IN 46227		
COUNT	RY CHARM VILLAG	<u>'</u>		INDIAN	APOLIS, IN 40221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DATE	
	used by the facil	ity. The policy indicated,	assignment. The Pharmacist				
	"7. At each shi	ift change, the narcotics			consultant shall review further		
	count should be verified by the oncoming and previous shift. Each narcotic sheet should be verified with the actual count of the medications; the narcotic sheet should be signed by both the oncoming				with the 60 day summary, and		
					report findings in summary rep	ort	
					to the DON and Executive Director.		
					Director.		
	_						
	and previous shift Employee Partners"				The DON shall in-service and		
	2. On 7/25/2014	from 11:20 a.m. to			create a schedule for the		
	12:30 p.m., medication cart #1 and medication cart #2 were observed to have				medication carts to be maintain	ned	
					in a clean, neat and locked		
	multiple stray pills in the bottom of each				stationary area.		
	drawer.						
	 a. Medication cart #1 had five tablets, two half tablets, one capsule, and one gel cap scattered throughout the bottom of the drawers. b. Medication cart #2 had eight tablets, two half tablets, one gel cap, and one whole capsule scattered throughout the bottom of the drawers. In the bottom of one drawer, a broken capsule was found, with the powder contents spilt all over the backside of the drawer. 				4. The DON shall monitor daily compliance. The Executive Director shall monitor weekly furee months. The Regional Manager shall monitor quarter	or ly	
					for compliance with this correct action. 5. This corrective action shall		
					completed by September 15, 2014.	De	
	of Nursing (DoN are not suppose them. There is rout the medication	12:15 p.m., the Director N) indicated, the drawers to have stray pills in not a set schedule to clean on carts, but the night e of looking at the and reordering					

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 48 of 71

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
11.512.111			A. BUILDING		07/28/2014			
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIER			S HWY 31 S				
COUNTR	RY CHARM VILLAGI	E	INDIANAPOLIS, IN 46227					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	NATE COMM ELTION			
1AU		e continued to indicate,	TAG	SELECTIVE 1	DATE			
	the facility would	,						
		medication carts to the						
	night nurse job d							
		5:20 p.m., the DoN						
	indicated, the fac	•						
	*	ome out to audit the						
		, but she was not sure						
	how often they co	ome out.						
	On 7/28/2014 at 9:00 a.m., the DoN							
		rage of Medication						
	•	and indicated the policy						
		ently used by the facility.						
		ated, "1. All medications						
	-	mmunity must be						
		clean, neat, LOCKED						
	stationary contain	ner or area"						
R000302	410 IAC 16.2-5-6(d	c)(6)						
	Pharmaceutical Se	ervices - Deficiency						
	(6) Over-the-count	ter medications must be						
	identified with the to (A) Resident name							
	(B) Physician nam	e.						
	(C) Expiration date) .						
	(D) Name of drug. (E) Strength.							
		ation, interview, and	R000302		09/15/2014			
	· ·	e facility failed to ensure		R 302 – Pharmaceutical Services - Deficiency				
	resident's over th	e counter medications		Del vices - Deliciency				

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 49 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WIN			07/28/	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		7212 U	S HWY 31 S		
	RY CHARM VILLAG			INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	1	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		rectly in 3 of the 4					
	facility medication carts observed in that				1. The corrective action as to		
		on bottles were found			three out of the four medicatio	n	
	with only reside	nt name and			carts is described below.		
	manufacturer lab	pels.					
	Fig. 41						
	Findings include).			2 and 3. Over the counter medications, prescription drug	S,	
	On 7/25/2014 from 11:30 a.m. to 12:10 p.m., the facility's medication carts were observed to have eleven bottles with only the manufacturer's information and the resident's name.				vitamins, and biologicals used		
					the residents in the facility are		
					labeled in accordance with		
					currently accepted professiona standards and principles include		
					appropriate accessory and	anig	
	resident's name.				cautionary instructions and		
	1. Cart #1 had R	esident #5's calcium			expiration dates. Resident over the counter medications are	er	
	bottle labeled wi	ith the resident's name			labeled with the resident name) .	
	and manufacture	er's label. Resident #44's			apartment number, stored and		
	Tylenol bottle w	as only labeled with the	administered with physician				
	_	and manufacture's label.			orders, including the date the		
	Resident #28's a	spirin bottle was labeled			OTC came into use by the resident.		
	with only residen	•			resident.		
	manufacturer's la						
					The DON shall in-service all		
		esident #8's aspirin bottle			nursing staff regarding the fac		
	with only the ma	anufacturer's label on it.			policy relating to over the cour medications, resident	iter	
	3. Cart #3 had R	Resident #22's fish oil			participation and facility protoc		
		ith the resident's name			for administering. The DON sl	nall	
		er's label. Resident #7's			complete a list of all residents using OTC medications and		
		ottle was only labeled			complete an OTC medication		
		-			audit of those affected residen	ts	
	with the resident's name and manufacturer's label. Resident #26's				weekly for 4 weeks, then every	/	
					other week for 8 weeks, then		
		D-3, aspirin, Tylenol,			monthly for 3 months.		
	and stool softene	er bottles were only					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2014
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN 46227	0112012017
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE COMPLETION PRIATE
TAG	labeled with the manufacturer's last of Nursing (DoN counter medication carts the resident's nannumber, and the eleven bottles shincorrectly. She the staff who are medication bottl responsible for last provided the Stopolicy, undated, was the one currous the policy indication stor room, each OTC labeled with the	12:15 p.m., the Director I) indicated, over the con bottles kept in the , should be labeled with me, the resident's room physician's name. The own to her were labeled continued to indicate, e there when the	TAG	The DON shall include over medications, the monitoring administering thereof in the nursing in-service schedule further compliance. 4. The Pharmacy consultant review the monthly OTC restlog to review for interaction other resident medications attreatments. The DON shall monitor daily for compliance Executive Director shall motweekly for three months. The Regional Manager shall motwarterly for compliance with corrective action. 5. This corrective action shall completed by September 18 2014.	and yearly for t shall sident with and e. The nitor ne nitor h this
R000349	on each resident. maintained under employee of the fa				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
			B. WING			07/28/2014	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the facility failed records contained documentation restatus (Residents insulin administrativity and nurse (Resident #B and records reviewed accurate documents accurate documents included and the second second reviewed on 7/2. Diagnoses included to, dementia (memory, personal hypertension (hi anorexia (loss of Physician orders indicated Reside code. State of Indiana Resuscitate Declaration of the second records in the second records in the second records reviewed on 7/2.	organized. ew and record review, It to ensure clinical d accurate and complete egarding residents' code is #50, #60, #46, and #A), ration (Resident #C), and ing progress notes d #C) for 6 of 8 resident d for complete and entation. E: I's clinical record was 3/2014 at 1:00 p.m. ded, but were not limited ental disorder affecting ality, and reasoning), gh blood pressure), and appetite). dated 3/28/2012, nt #50 was to be a full Out of Hospital Do Not aration and Order was 19/12/2013, by Resident	ROO	00349	R 349 – Clinical Records - Noncompliance 1. The correction action for the Residents identified in the alle deficiency accomplished is as follows: a. Resident 50 Reside Code Status was reviewed an verified with the Resident and Responsible Party. The Resid and physician signed off on the desired code status. The recois consistent with the Resident wishes. b. Resident 60 is no longer a resident of the community. c. Resident 46 Resident code Status was review and verified with the Resident and Responsible Party. The Resid and Physician signed off on the desired code status. The recois consistent with the Resident wishes. d. Resident A Resident Code Status was reviewed an verified with the Resident and Responsible Party. The Resident Code Status was reviewed an verified with the Resident and Responsible Party. The Resident Responsible Party.	nt d /or lent e pord t's nt t d /or e t's	09/15/2014

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 52 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WIN			07/28/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIEF	8			S HWY 31 S		
COUNTR	RY CHARM VILLAG	E			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)N
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	Country Charm	Village			and Physician signed off on th		
	Cardio-Pulmona	ry Resuscitation			desired code status. The record is consistent with the Resident		
	Directive dated	1/21/2013, indicated			wishes.	•	
	Resident #50 would like				Wiches.		
	cardiopulmonary resuscitation (CPR)				e. Resident B The nurs	ing	
	preformed in an	•			staff has been in-serviced		
					regarding clinical nursing char	·	
	Country Charm	Village Resident			and all nursing shall use comp date and time in a legible and	lete	
	-	rmation Sheet, undated,			factual manner, with signature	of	
	indicated Resident #50 would like CPR performed in an emergency.				writer for each entry in the		
					resident's chart.		
					f. Resident C The nurs	ng	
		Service Plan dated			staff has been in-services regarding clinical nursing char	ing	
	-	ated Resident #50 would			and forms. The diabetic flow	iiig	
	like CPR preform	med in an emergency.			sheet has been included with	he	
					residents chart for accurate Cl	3G	
	On 7/25/2014 at	9:00 a.m., the Director			monitoring. Nusing shall use		
	of Nursing (DoN	I) indicated, she talked to			complete date and time in a	L	
	resident #50's Po	OA and Resident #50			legible and factual manner, wi signature of writer for each en		
	should be a do n	ot resuscitate (DNR).			in the resident's chart.		
		,					
	In review of Res	sident #50's chart many					
		were found regarding her					
	code status.						
					2. This deficiency may affect a	II I	
	1b Resident #60)'s closed clinical record			residents. The DON shall perfe		
		n 7/24/2014 at 9:10 a.m.			a complete chart audit to revie	w	
		ded, but were not limited			residents' code status, insulin		
	_				administration, and nursing charting of progress and other		
	to, hypertension (high blood pressure),				notes. The DON shall review a	nv	
		ailure (kidney failure),			identified resident code status	•••	
	and anemia (low	red blood cell count).			with the facility resident		
		1 . 10/42/2015			emergency information sheet.		
	<u> </u>	s dated 9/12/2013,			Questions of accuracy shall be		
	indicated Reside	ent #60 was to be a			identified and discussed with t	ne	

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 53 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATI			TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
			A. BUI B. WIN			07/28/	2014	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			S HWY 31 S			
COLINIT		· F						
COUNTR	RY CHARM VILLAG	JE		INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	"***full code **	** unless otherwise stated			resident, the residents' family			
	by advance direct	ctive."			physician.			
	Dhygiaian ardar	dated 0/12/202						
	I -	s dated 9/12/203,			The DON shall review each			
	indicated Resident #60 was a no code.				resident chart to determine the	The DON shall review each		
					status of advance directives	,		
	State of Indiana	Out of Hospital Do Not			determination and appropriate			
	Resuscitate Declaration and Order was signed and dated 10/15/2012, by Resident #60.				documentation. The DON sha			
					work with the resident and the			
					families to identify, list, and			
	1100.			document accurately those listed				
	Country Charm Village				desires.			
	Cardio-Pulmona	ry Resuscitation						
	Directive dated	1/15/2013, indicated			2. To analyze this deficiency de			
	Resident #60 w	ould like			3. To ensure this deficiency do not recur, the DON shall creat			
	cardiopulmonary	y resuscitation (CPR)			and monitor a specific residen			
	preformed in an				listing identifying those residents			
	preformed in an	emergency.			who have a specific code status,			
		77'II D ' I .			that shall reviewed and monitor			
	<u> </u>	Village Resident			on quarterly basis when			
		rmation Sheet, undated,			assessments and service plan	s		
	indicated Reside	ent #60 would like to be a			are reviewed and updated.			
	DNR.							
	Assessment and	Service Plan dated			The DON shall in contine all			
		ated Resident #60 would			The DON shall in-service all nursing staff regarding current			
					and appropriate clinical charting			
	like to be a DNF	ζ.			and methods, including charting			
					thinning, entering lab and	· 9		
	On 7/24/2014 at	1:45 p.m., the DoN			physician orders, and best			
	indicated, Resid	ent #60 is no longer a			practice use of the sections of	the		
	-	icility. She would not be			resident chart.			
	able to find out what code status he was							
		with code status ne was						
	suppose to be.				The DON shell			
					The DON shall in-service all	•		
	In review of Res	sident #60's chart many			nursing staff regarding diabeti	ن		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
			B. WING		07/28/2014		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
TAG	inconsistencies of code status. 1c. Resident #46 reviewed on 7/2-Diagnoses included to, dementia (memory, person hypertension (hit Crohn's disease disease). Physician orders indicated Reside "***full code ** by advance direct Out of Hospital Declaration and dated 11/10/201 Country Charm Cardio-Pulmona Directive dated Resident #46 we the case of an entire Country Charm Emergency Info indicated Resident DNR.	were found regarding his o's clinical record was 4/2014 at 11:30 a.m. ded, but were not limited ental disorder affecting ality, and reasoning), gh blood pressure), and (inflammatory bowel o's dated 12/26/2013, ent #46 was to be a est unless otherwise stated ettive." Do Not Resuscitate Order was signed and 0, by Resident #46. Village ry Resuscitation 4/4/2013, indicated ould like to be a DNR in energency. Village Resident rmation Sheet, undated, ent #46 would like to be a	IAG	resident monitoring, including use of diabetic flow sheets, signing and documenting the administering of the sliding so insulin, dates, times, and accurately recording the capi blood glucose reading form. The DON shall be responsible completing audits of all service plans for residents receiving diabetic monitoring weekly for weeks, then every other week weeks, then every other week weeks, then monthly for 3 months. Results shall be reported to the QA committee and Executive Director for review further corrective actions as deemed necessary. 4. The Executive Director shamonitor weekly for six months and the Regional Manager shamonitor the Executive Director compliance quarterly. 5. This corrective action shall be completed by September 15, 20	g the cale cale cale cale cale cale cale cal		
		Service Plan dated ated Resident #46 would					

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 55 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			07/28/2014	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			S HWY 31 S		
COUNTR	RY CHARM VILLAG	Ε			APOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	like to be a DNR	₹.					
	On 7/25/2014 at 9:00 a.m., the DoN						
		ent #46 is suppose to be a					
	DNR in an emer	* *					
	Divie in un onio	geney struction.					
	In review of Res	sident #46's chart many					
		were found regarding his					
	code status.						
	code status.						
	1d. Resident #A's clinical record was						
	reviewed on 7/24/2014 at 2:00 p.m.						
		ded, but were not limited					
	•	lar accident (blood flow					
		rain, causing brain cell					
	·	sided hemiparesis					
	`	ss on one side of the					
		sion (high blood pressure)					
		nence (strong sudden					
	need to urinate d	lue to bladder spasms).					
	D1 · · · ·	1 / 1 5 /20 /2012					
	_	s dated 5/30/2012,					
	indicated Reside	ent #A was to be a DNR.					
	Country Charm	Village					
	Cardio-Pulmona	· ·					
		8/25/2012, indicated					
		uld like cardiopulmonary					
		PR) preformed in an					
	emergency.						
	Country Class	Willogo Dogidant					
	1	Village Resident					
	1 -	rmation Sheet, undated,					
	ındıcated Reside	ent #A would like to have					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	CON	TE SURVEY MPLETED 28/2014		
	PROVIDER OR SUPPLIER RY CHARM VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	CPR in an emergency situation.						
	On 7/25/2014 at 9:00 a.m., the DoN indicated, Resident #A would like to have CPR performed in the case of an emergency.						
	In review of Resident #A's chart many inconsistencies were found regarding his code status.						
	On 7/25/2014 at 9:00 a.m., the DoN indicated it is facility policy to use the information on the Country Charm Village Cardio-Pulmonary Resuscitation Directive sheet in case of an emergency. She was not sure why the clinical records had inconsistent documentation regarding code status. She continued to indicate, the charts may have not been updated when code status preferences had been changed.						
	On 7/28/2014 at 9:00 a.m., the DoN provided Advanced Directive: Do Not Resuscitate (DNR), undated, and indicated the policy was the one currently used by the facility. The policy indicated, " 6. The Director of Health Services or designee is responsible for conducting annual review of all advanced directive orders, and ensuring that all qualified staff are aware of the resident's wished regarding resuscitation."						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391

-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00 	COMPLETED 07/28/2014			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN) REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	provided Clinical indicated the pol- used by the facility must records on each in must be completed documented, react systematically or 2. The clinical rewas reviewed on Diagnoses include to, congestive her pressure, diabete A recapitulated of for June 2014, in to have Accuched daily at bedtime, sliding scale insuffactory and a physician's order Accucheck was also had a physician's order for 5 units. The physician's order for 5 units.	dily accessible, and						

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 58 of 71

	FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMP	E SURVEY LETED 8/2014		
	ROVIDER OR SUPPLIER Y CHARM VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Sheets for May, documentation of administration with incomplete. The documentation of members administration with the documentation of members administration. The flow lacked document insulin administration of the side of the second of the side of the blood sugar of the sliding second	flowsheets lacked if name or initials of staff stering the sliding scale wsheet for July 2014, tation of sliding scale ration at bedtime for the Accucheck results at the dates indicated tuld have received sliding 7/15, 7/17, 7/18, 7/19, and 7/24/14. The with the Director of ton 7/25/14 at 12:15 p.m., and the documentation of the documentation of the sults and administration the insulin on the the tests was difficult to read the termine how much the thad received each andicated the initials of the stering the dose, the site tation, as well as the the tered should have been						

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 59 of 71

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	COMPLETED				
			B. WING			/2014		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	DE			
COUNTR	RY CHARM VILLAG	E	7212 US HWY 31 S INDIANAPOLIS, IN 46227					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)		
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE		
1710		ection of the policy	17.0	<u> </u>		DATE		
	•	All diabetic residents						
	•	orders for capillary						
		CBG) monitoring will						
	have low and hig	gh parameters for						
	physician notific	ation included with the						
	CBG order9. R	Routine and random CBG						
	levels for each re	esident will be recorded						
	on the Capillary	Blood Glucose Readings						
	Form. Insulin coverage amounts will							
	also be recorded on this form" 3a. The clinical record of Resident #C							
		7/25/14 at 9:20 a.m.						
	Diagnoses includ	ded, but were not limited						
	_	eart failure, high blood						
	, ,	es, and depression.						
	The manine and	anasa natas fan Mari						
		gress notes for May, 014 for Resident #C						
		tation of the time of the						
		ete dates for multiple						
		ord. The time was						
		ys" or "Evenings" or was						
	-	were recorded as the						
	_	out lacked the year of the						
	entry.	at tabled the jour of the						
) -							
	During an interv	iew with the Director of						
	_	on 7/24/14 at 4:05 p.m.,						
	U \ /	ed the staff should use a						
		nd time of each entry in						
	the record.	•						
						1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/28/2014
	PROVIDER OR SUPPLIER		STREET A 7212 US	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated the polused by the facili "5date and tin accurate, legible documentation sl made here" 3b. The clinical r was reviewed on Resident #B was on 5/31/13. Diag were not limited Alzheimer's diser blindness in the l During a review nursing progress notes, and dietary completed date a nursing progress recorded as "Day time was missing recorded as the re the year of the er progress notes la lacked times of er was recorded as the	of Assistance" and icy was the one currently ity. The policy indicated, mes should be listed and and factual hould be the only entries record of Resident #B 7/23/14 at 1:05 p.m. admitted to the facility gnoses included, but to, hypertension, ase, depression, and eft eye. of the clinical record, the notes, activity progress y progress notes lacked and time of entries. The notes had times yes" or "Evenings" or the g. Some dates were nonth and day but lacked aftry. The activity cked complete dates and entry. Each date entered the month and year, such da time indication. The notes contained out lacked a time			

State Form Event ID: 425W11 Facility ID: 003283 If continuation sheet Page 61 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2014
COUNTR	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R000352	Nursing (DoN) of the DoN indicated complete date and the record. On 7/28/14 at 2:4 provided an unda "Documentation indicated the pollused by the facility "5date and the accurate, legible documentation simade here" 410 IAC 16.2-5-8. Clinical Records (e) The clinical records (following: (1) Sufficient information (2) A record of the (3) Services provided (4) Progress notes (4) Progress notes (5) Based on record the facility lacked services provided required assistant ordered by the plensure a catheter	ated policy titled of Assistance" and icy was the one currently ity. The policy indicated, mes should be listed and and factual hould be the only entries 1(e)(1-4) Noncompliance cord must contain the mation to identify the resident 's evaluations.	R000352	R 352 – Clinical Records - Noncompliance 1. The corrective action for Resident have his/her catheter flushed twice and to train all appropris staff that this must be done. It also in the service plan. 2 a 3. The DON shall be respons for completing an observation resident chart audit to list and identify resident specific phys and treatment orders. This sh	ate t is and ible al

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
			B. WIN			07/28/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1			
COLINITE	DV CLIADNA VIII I A C	· F			S HWY 31 S		
COUNTR	RY CHARM VILLAG	DE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	e:			include specific treatment flow		
					sheets. The DON shall audit a		
	The clinical reco	ord of Resident #C was			insure all treatment flow sheet	S	
		5/14 at 9:20 a.m.			are identified and referenced		
					within the residents' service plate to insure timeliness and	an	
	_	ded, but were not limited			completeness. The DON sh	all	
	_	eart failure, high blood			in-service all nursing staff with		
	pressure, diabete	es, and depression.			appropriate charting methods		
					treatment flow sheets, physicia		
	1. A recapitulate	ed of the physician's			orders, and coordination of oth		
	_	2014, with an origination			services with outside providers		
		indicated Resident #C			The DON shall be responsible	for	
	was to have T.E.				completing and observational		
					nursing shadowing regime to	•••	
	· ·	sm-deterrent hose)			observe, teach, and educate w		
	applied every me	orning and removed at			best practices to the treatment flow sheet activity. The DON s		
	bedtime for eder	na.			be responsible for continuing	IIali	
					such nursing treatment		
	During a review	of the Treatment Flow			observations with the nursing		
	-	June, and July 2014, the			staff by witnessing and observ	ing	
	1				treatments weekly for 4 weeks		
		of the knee high T.E.D.			then every other week for 8		
		and removal was blank,			weeks, then monthly for 3		
	indicating the ho	ose were not applied and			months. Results shall be report		
	removed as orde	ered.			to the QA team, the Executive		
					Director, and the residents' primary care physician as		
	The nursing prog	gress notes from April			needed. 4. The Executive		
		ly 2014 for Resident #C			Director shall monitor weekly f	or	
		tation of the resident			six months. 5. This corrective		
					action shall be completed by		
		ng to wear the T.E.D.			September 15, 2014.		
	hose.						
	During an interv	riew with the Director of					
	Nursing (DoN)	on 7/25/14 at 12:15 p.m.,					
		ed Resident #C was not					
		nt with the T.E.D. hose					
	and the starr sho	ould have indicated on the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC		COMPLETED
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	00	07/28/2014
			B. WING		0772072014
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE	
COUNTR	RY CHARM VILLAG	E		S HWY 31 S IAPOLIS, IN 46227	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		hose were refused. The			
		he staff should have			
		the Treatment Flow Sheet			
		communication book to			
		to the refusal by the			
	resident.				
	2. A recapitulate	ed of the physician's			
	•	2014, indicated Resident			
		catheter irrigations twice			
	weekly via Hom	C			
	1 -	of the irrigation order			
	was 4/17/14.	01 010 111 9 001011 01 00 1			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	During a review	of the Treatment Flow			
		June, and July 2014, the			
	1	of catheter irrigations was			
	blank.	of catheter irrigations was			
	olulik.				
	The clinical reco	ord of Resident #C lacked			
	documentation of	of services provided by			
	Home Health.	1			
	During an interv	riew with the DoN on			
	7/25/14 at 12:15	p.m., the DoN indicated			
	the catheter irrig	ations were completed			
	by Home Health	and not the facility staff.			
	The DoN indica	ted the documentation of			
	the visits by Hor	ne Health were			
	I -	separate binder. The			
		binder marked Home			
	*	ated the records should			
	be in the binder	under the resident's			
	name. No record	ds were found for			
	Ī		I	I	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00	COM	PLETED	
			B. WING			28/2014
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	DE	
COUNTR	RY CHARM VILLAG	E		S HWY 31 S APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SON CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated the Ho the nurse when t did not think the placed a note in The nursing prog 2014 through Jul lacked document receiving service On 7/28/14 at 9: provided an unda Providers policy was the one curr "6All medicate can only be done orders and must Community for I Documentation in	he binder. The DoN me Health staff report to he visit is completed, but Home Health staff the chart for each visit. gress notes from April ly 2014, for Resident #C tation of the resident es from Home Health. 00 a.m., the DoN ated Third Party Care , and indicated the policy ently used by the facility. ations and or treatments e with proper physician be provided to the Resident records. must be provided after ing care/assistance				
R000410	completed within to admission or upor forty-eight (48) to The result shall be induration with the and by whom admission or upon the complete with the complete within the complete wit	. , . ,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/28/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		JS HWY 31 S		
	RY CHARM VILLAG	E		NAPOLIS, IN 46227		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	_	tive tuberculin skin test				
		receding twelve (12) ine tuberculin skin testing				
	l '	two-step method. If the				
		ve, a second test should				
		in one (1) to three (3)				
		st test. The frequency of				
	1 .	depend on the risk of				
	infection with tube	rculosis. ho have a positive reaction				
		kin test shall be required				
		ray and other physical and				
	laboratory examin	ations in order to complete				
	a diagnosis.					
	Based on intervi	ew and record review,	R000410	R 410 – Infection Control -	09/15/2014	
	the facility failed	l to ensure residents		Noncompliance 1. The	D	
	received screening	ng for tuberculosis (lung		corrective action for residents 18, 60 and 61 that was	В,	
	disease) at admis	ssion and annually for 4		accomplished was completed		
	of 8 residents in	that residents did not		screening for tuberculin. 2.		
	receive tuberculi	in skin tests (screening		This alleged deficiency could		
		ease called tuberculosis).		affect all residents and the DC		
		18,#60, and #61)		shall perform a resident audit	to	
	(Residents #B, #	10,1100, and 1101)		verify all residents are in compliance with their annual		
	Findings include			tuberculin test, and initiate a r	new	
	Tilldings include	·•		test where needed. 3. To		
	1 David //101	alinian manad		ensure that this alleged deficie	ency	
		s clinical record was		does not recur, the DON has		
		5/2014 at 1:20 p.m.		developed, and implemented		
	~	ded, but were not limited		infection control policies and procedures to ensure controlle	ed	
	, , ,	(high blood pressure),		practices designed to provide		
	cerebrovascular	accident (blood flow to		safe, sanitary and comfortable		
	the brain is stopp	ped, causing brain cell		environment intended to help		
	death), and perni	icious anemia (decrease		prevent the development and		
	in red blood cells	s caused by abnormal		transmission of disease and		
	absorption of vit	•		infection. The DON shall in-service nursing staff regard	ina	
	F	<i>)</i> -		the resident admission	"'9	
	Resident #18 wa	s admitted 6/30/2014.		assessment which includes th	e	
	1 10 Ma	5 admitted 0/50/2017.		tuberculin skin test performan	ce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			07/28/	2014
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			S HWY 31 S		
COLINTE	RY CHARM VILLAG	<u>.</u>			APOLIS, IN 46227		
				INDIAN	AI OLIO, IN 40221		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Documentation 1	from a previous residence			upon admission, and annual		
	dated 9/5/2013 a	at 3:30 p.m., indicated			thereafter. The DON shall		
	Resident #18 had	d received a tuberculin			create and maintain a resident tuberculin test listing, identifyir		
	test.				the annual renewal month for	ig	
					each resident requiring their		
	No documentation	on was found indicating			annual tuberculin test, and sha	all	
		· ·			review and monitor for		
		ceived a tuberculin test			compliance. 4. The Execut	tive	
	_	or to admission or upon			Director will audit monthly		
	admission to the	facility.			move-in to ensure the correcti	ve	
					action is occurring. 5. The date this corrective action shall	ll bo	
	On 7/28/2014 at	9:00 a.m., the Director			completed by is September 15		
	of Nursing (DoN	N) indicated, she was			2014.	,	
	unable to locate documentation indicating						
		d received a tuberculin					
		s prior to admission or					
		-					
	_	She continued to					
	· ·	nt #18 had received the					
	start of a tubercu	ılin test this past					
	weekend.						
	2. Resident #61's	s clinical record was					
	reviewed on 7/2	3/2014 at 2:30 p.m.					
		ded, but were not limited					
	~	ental disorder affecting					
	,	· ·					
		ality and reasoning),					
	`	er causing irregular blood					
	sugars), and hyp	ertension (high blood					
	pressure).						
	No documentation	on was found indicating					
	Resident #61 red						
	tuberculin test in						
	tubercumi test ii	1 2013 01 2014.					
	0 7/00/2017	11.10					
	On 7/28/2014 at	11:40 a.m., the DoN					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 07/28/	ETED	
	PROVIDER OR SUPPLIEI		7212 U	ADDRESS, CITY, STATE, ZIP COE S HWY 31 S APOLIS, IN 46227	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	documentation i	as unable to locate any ndicating Resident #61 aberculin test in 2013 or				
	reviewed on 7/2 Diagnoses inclu to, hypertension end stage renal f	s clinical record was 4/2014 at 9:10 a.m. ded, but were not limited (high blood pressure), failure (kidney failure), red blood cell count).				
	No documentati Resident #60 red tuberculin test in					
	indicated, she w documentation i had received a to	1:45 p.m., the DoN as unable to locate any indicating Resident #60 aberculin test in 2013 or ents receive a tuberculin ter.				
	reviewed on 7/2 Resident #B was on 5/31/13. Dia were not limited	ecord of Resident #B was 3/14 at 1:05 p.m. s admitted to the facility gnoses included, but to, hypertension, ease, depression, and left eye.				
	documentation of	ord of Resident #B lacked of tuberculosis (TB) a 3 months of admission				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	00		E SURVEY PLETED
THE PLAN OF COLUMN TO SHEET OF THE PROPERTY OF		A. BUILDING			8/2014	
			B. WING	ADDRESS, CITY, STATE, ZIP COI		
NAME OF F	PROVIDER OR SUPPLIEF	8		S HWY 31 S)L	
COUNTR	RY CHARM VILLAG	E		APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT ACTUAL CONTROL OF CONTROL OF CORRECT ACTUAL CONTROL OF CONTROL OF CORRECT ACTUAL CONTROL OF		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
TAG		mentation of screening	IAG			DATE
	upon admission	•				
	upon uumssion	5/51/15.				
	During an interv	riew with the Director of				
		on 7/23/14, at 1:45 p.m.,				
	• , ,	ed the results of TB tests				
	were kept in a se	eparate binder and she				
	was not able to f	and results for Resident				
	#B. The DoN in	ndicated Resident #B had				
	a TB test at anot	her facility on 1/21/13,				
	but was not give	n a TB test upon				
	admission to this	s facility.				
		00 a.m., the DoN				
	provided the pol	•				
	_	nunicable Disease				
	_	ed 12/2004, and indicated				
		ne one currently used by				
		procedure section of the				
		, "3. All residents will				
		n skin test accomplished				
	_	ne Mantoux method ninistered at the time of				
	` //	thin three (3) months				
		on11. The Tuberculosis				
	•	d will be updated				
	annually for each	-				
	_	f the one-step Mantoux				
		ing record will be				
		e resident's clinical				
	record permaner	ntly"				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
			A. BUILDING B. WING		07/28/2014
				ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			2 US HWY 31 S	
COLINTE	RY CHARM VILLAG	-		ANAPOLIS, IN 46227	
	T CHARW VILLAG	<u>L</u>	INDI	ANAFOLIS, IN 40227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000414	410 IAC 16.2-5-12				
	Infection Control -	<u> </u>			
	, , , , , , , , , , , , , , , , , , ,	st require staff to wash			
		ach direct resident contact shing is indicated by			
	accepted profession				
		ation, interview, and	R000414	R 414 – Infection Control -	09/15/2014
		ne facility failed to ensure	1000714	Deficiency 1. The correcti	
	· ·	-		action as it affected Resident	
		ir hands between direct		and 34 and LPN 1 that has b	
		dents for 1 of 5 observed		accomplished is that LPN 1 h	
	•	es in that the staff		been individually re-educated	
	member did not	wash her hands between		to the infection control policy	
	residents. (Resid	dents #44 and #32) (LPN		specifically hand washing. The DON shall review, follow, and	
	#1)			monitor LPN 1 for thirty days	
	,			ensure compliance. 2 and	
	Findings include			Because this deficiency can	
	Tilidings ilicidde	•		all residents and threaten the	
	0 7/05/0014.5	11.05		health of employees, the DO	N
		om 11:05 a.m. till 11:20		shall create a new hand was	hing
	•	s observed administering		procedure and post where	
	medication to Re	esident #44. There was		nursing staff can review as a	
	no observation n	nade after this		reminder. The DON shall in-service the nursing staff or	n the
	medication pass	of LPN #1 washing her		specifics of the procedure wh	
		hen continued to look for		shall include the use of	
		nce LPN #1 found		antibacterial soap, working u	ра
		e administered his		lather on hands, wrists, and	
				forearms, and cleansing nails	
	afternoon medica	ation.		fingernails; rinsing hands, an	
				wrists thoroughly with running	
		11:20 a.m., LPN #1		water, before drying hands w paper towels, then disposing	
	indicated, it is fa	cility policy for staff to		towels in a covered garbage	
	wash their hands	after contact with		The DON and Executive Dire	
	residents. LPN #	#1 continued to indicate,		shall utilize the same hand	
		washed her hands		washing procedure as a part	of
		sident's medication pass.		the orientation of new employ	
	3000, 3011 00011 103	Authorited publication publication		hires. The DON and Executiv	/e
	On 7/25 2014 -4	12:15 mm the Director		Director shall post the hand	
	On //25.2014 at	12:15 p.m., the Director		washing procedures with each	on

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE B. WING	DING	nstruction 00	(X3) DATE COMPL 07/28 /	ETED	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			7212 US	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN 46227		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	P	REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	policy is to sani resident. Staff of sanitizer two tire and water the the hands. On 7/23/2014 a Marketing Dire precautions - staff of the currently used by indicated, " A	N) indicated, the facility's tize between each can use the hand gel mes, but needs to use soap aird time of washing their to 11:40 a.m., the ctor provided the andard Policy, dated 2002, we policy was the one by the facility. The policy ll staff must wash their re and after any direct ident"			department, and shall monitor compliance. The hand washin infection control will include all shifts seven days a week. The Licensed Nurse on duty for ear shift shall monitor compliance. 4. The Executive Director will audit monthly move-in to ensure the corrective action is occurring. The date this corrective action shall be completed by its September 15, 2014.	g/ ch re ng.	

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